

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

08626

08606

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b x2 Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4711 Derussey Blvd. Pkwy		d. STREET ADDRESS 4711 Derussey Blvd. Pkwy	
3. NAME OF DECEASED (Type or print) Clara Delp Anderson		4. DATE OF DEATH Month Aug. Day 4 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/75
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Delp		14. MOTHER'S MAIDEN NAME Anna E. Spangenberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Arthur D. Anderson, Same as Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary anemia 30 yrs.		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/57	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince Geo Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24. REC'D BY REGISTRAR Bethesda, Maryland	
24a. REGISTRAR'S SIGNATURE Bessie M. Thompson		24b. REGISTRAR'S SIGNATURE 8-7-57	

BUREAU V. 2

AUG 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

08627		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		08607	
Item 9, Film G219, 8/23/57		CERTIFICATE OF DEATH		Reg. Dist. No. 218	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD2 Germantown</u>		c. LENGTH OF STAY IN 1b <u>45 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD2 Germantown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>RD2 Germantown</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mamie Elizabeth Anderson</u>		4. DATE OF DEATH <u>Aug. 15, 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23 1881</u>	9. AGE (In years last birthday) <u>74 1/2</u> yrs.	IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Seneca, Md.</u>	
13. FATHER'S NAME <u>Golden Driver</u>		14. MOTHER'S MAIDEN NAME <u>Harriet N. Driver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Clara Green, Sister, RD2 Germantown</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 Mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Congestive Heart Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>1-6</u> , 19 <u>57</u> , to <u>8-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-15</u> , 19 <u>57</u> , and that death occurred at <u>8:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson, M.D.</u>		ADDRESS (Street, city or town, state) <u>RD1 Gaithersburg, Md.</u>		DATE SIGNED <u>8-15-57</u>	
PHYSICIAN'S NAME (Type) <u>C. LIVE E. JACKSON</u>					
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seneca, Md.</u>	
22d. LOCATION (City, town, or county) (State) <u>Seneca, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden - Rockville, Md.</u>		ADDRESS <u>—</u>		24. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>AUG 20 1957</u>					

AUG 20 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08608

08628

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>914 PHILADELPHIA AVE</u>		d. STREET ADDRESS <u>914 PHILA. AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>E</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 17-1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMM. MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM S. ANDERSON</u>		14. MOTHER'S MAIDEN NAME <u>IDA WEISNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>THOMAS H. ANDERSON</u>		Address <u>4021 LINDALE DR. BETHESDA MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 MONTHS</u> <u>2-3 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>MAY</u> _____, 19 <u>56</u> , to <u>AUG 1</u> _____, 19 <u>57</u> , that I last saw the deceased alive on <u>AUGUST 1</u> _____, 19 <u>57</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D.		ADDRESS (Street, city or town, state) <u>8907 GEO. AVE. S.S. MD.</u> DATE SIGNED <u>8/1/57</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-5-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON - D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u>		ADDRESS <u>1400 Chapin St</u>	
24a. REC'D BY REGISTRAR <u>WIG 6</u>		24b. REGISTRAR'S SIGNATURE <u>James A. Roberts</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Dist. No.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		MILITARY SERVICE		CIVIL SERVICE		SOCIETY		OTHER	
JAMES H. HARRIS		M		45		1912		BALTIMORE, MD		W		HIGH SCHOOL		LABORER		M		METHODIST		U.S. ARMY		U.S. NAVY		U.S. AIR FORCE		U.S. MARINE CORPS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS DRUGS		PREVIOUS ACCIDENTS		PREVIOUS TRAUMA		PREVIOUS INJURY		PREVIOUS DISEASE		PREVIOUS SYMPTOMS		PREVIOUS SIGNS	
AUG 4 1957		BALTIMORE, MD		HEART DISEASE		NATURAL		2 WEEKS		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS		DATE	
J. H. HARRIS		AUG 5 1957		J. H. HARRIS		AUG 5 1957		J. H. HARRIS		AUG 5 1957		J. H. HARRIS		AUG 5 1957		J. H. HARRIS		AUG 5 1957		J. H. HARRIS		AUG 5 1957		J. H. HARRIS		AUG 5 1957	

BUREAU V. S.

AUG 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seneca	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River		e. STREET ADDRESS 402 Blandford St., Apt. 5	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Marvin Middle Earl Last Atwell		4. DATE OF DEATH Month Aug. Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/35
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months 21 Days 21	IF UNDER 24 HRS. Hours 21 Min. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Tree Sergeant	11. BIRTHPLACE (State or foreign country) Marion. Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Philip W. Atwell	
14. MOTHER'S MAIDEN NAME Ethel Louise Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Police Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9298 DUE TO drowning Conditions, if any, which gave rise to immediate cause (b) drowning (c), stating the underlying cause lost. DUE TO drowning		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while diving in Pot. R., Seneca Md.	
20c. TIME OF INJURY Month, Day, Year Hour 9 o. m. 8/18/57 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac R.		20f. (City or town) Seneca Montg. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-57	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg. Md.	
24a. REC'D BY REGISTRAR 8/20/57		24b. REGISTRAR'S SIGNATURE Laurel Kratz	

RECEIVED

AUG 21 1957

BUREAU V. S.

MAINTAINING STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS 18

1-6000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

08630

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 119 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Jacksonville 48x-3				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland			
d. STREET ADDRESS 1619 Perry Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elmer Middle Nat Last BAILEY				4. DATE OF DEATH Month August Day 7 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 May 1901	
9. AGE (In years last birthday) yrs. 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Edward BAILEY				14. MOTHER'S MAIDEN NAME XXXXXXXXXX Emily DICKERMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I&II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Wife) Vera Burke BAILEY (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma left lung 162x DUE TO with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH at least 8 months.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11 April , 19 57 , to 7 August , 19 57 , that I last saw the deceased alive on 7 August , 19 57 , and that death occurred at 1:50 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Larry J. Hines M.D. U.S. Naval Hospital, Bethesda, Md. 8-8-57							
ACTUAL SIGNATURE Larry J. Hines M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) LARRY J. HINES, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR DATE 8-8-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MD 10-100 (Rev. 1-1-57)

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. RACE [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. DATE OF BIRTH [REDACTED]	
7. PLACE OF DEATH [REDACTED]		8. DATE OF DEATH [REDACTED]		9. TIME OF DEATH [REDACTED]		10. CAUSE OF DEATH [REDACTED]		11. MANNER OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF DECEASED [REDACTED]		15. SIGNATURE OF DECEASED [REDACTED]		16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF DECEASED [REDACTED]	

RECEIVED
AUG 13 1957
BUREAU V. 2

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>5 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>RFD 3 Box 64</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Venia Antoinette Bailey</u>				4. DATE OF DEATH Month Day Year <u>Aug. 5 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24-1868</u>	
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>Tannin Co. Texas</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Hiram Terry</u>				14. MOTHER'S MAIDEN NAME <u>Edna Frances Pyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>M.F. Bailey (son) & Hospital records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis. Senility</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>1 year</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-3-</u> 19 <u>57</u> to <u>8-5-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>8-5-</u> 19 <u>57</u> , and that death occurred at <u>10:18 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u>				DATE SIGNED <u>8/5/57</u>			
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>[Signature]</u>			
PHYSICIAN'S NAME (Type) <u>J. M. Bird</u>				<u>Sandy Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>Aug 6 1957</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 6 1957

RECEIVED

08632

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Canada Maryland b. COUNTY British Columbia XXXXXXXXXXXX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park Vancouver 90X-3			
f. STREET ADDRESS Apt. 204, 878 Cilford				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Mills Last BANGIT				4. DATE OF DEATH Month August Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 August 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Navaro BANGIT				14. MOTHER'S MAIDEN NAME Louise Mary MILLS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Edward N. BANGIT (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis, postop. 756.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Superficial lacerations DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hours 33 hours						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 August , 19 57 , to 6 August , 19 57 , that I last saw the deceased alive on 6 August , 19 57 , and that death occurred at 7:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 8-6-57							
ACTUAL SIGNATURE Martin P. Plaut		M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) Martin P. Plaut, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS 755 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 8-6-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050394XVL

08633

CERTIFICATE OF DEATH

08613

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>South Carolina</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaufort</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>				d. STREET ADDRESS <u>2311 Allison Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Keith</u> Middle <u>Evans</u> Last <u>BATES</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 February 1938</u>	9. AGE (In years lost birthday) yrs. <u>19</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Sidney Walter BATES</u>			14. MOTHER'S MAIDEN NAME <u>Enid Steedley</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(Father) Sidney W. Bates (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia</u> <u>603X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pyelonephritis, Chronic</u> DUE TO (c) <u>Stricture Left ureter and atrophy of Rt. kidney</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>30 July</u> , 19 <u>57</u> , to <u>21 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 August</u> , 19 <u>57</u> , and that death occurred at <u>9:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert B. Muth</u>			M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>8-22-57</u>				
PHYSICIAN'S NAME (Type) <u>Robert B. Muth, LT, MC, USN</u>			<u>U.S. Naval Hospital, Bethesda, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beaufort, South Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u> ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>Mary E. Parrelly</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

AUG 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

Cause: <u>Item 18 Film 220 9-9-57</u>										08614	
MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08614	
Pending										213	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville R - 2</u>			c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rockville R - 2</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>South Glen Rd.</u>					d. STREET ADDRESS <u>1 South Glen Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Steven Robert's Beal</u>			First Middle Last		4. DATE OF DEATH <u>8/6/57</u>		Month Day Year <u>19</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/7/1954</u>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jeremiah C. Beal</u>					14. MOTHER'S MAIDEN NAME <u>Beverly Beauchamp</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Father- Item 2.</u>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocarditis due to</u> <u>096.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fulminant infection</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>8/7/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>8/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>					ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 9 1957</u>				
							24b. REGISTRAR'S SIGNATURE <u>Samuel Traynor</u>				

BUREAU V. 5

AUG 9 1957

RECEIVED

08635

CERTIFICATE OF DEATH

08615

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 ROCKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		d. STREET ADDRESS 1618 BLANFORD ST.	
3. NAME OF DECEASED (Type or print) BABY First Middle Last MALE BEALL		4. DATE OF DEATH Month AUG Day 29 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 29 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 1 IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min. 10
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HAROLD E BEALL		14. MOTHER'S MAIDEN NAME FRANCES GRAHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HAROLD E BEALL - SAME - FATHER		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Cardiac Anomalies; Transposition of DUE TO (c) aorta, Pulmonary stenosis, Intraventricular septal defect, Tetralogy.		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH AND NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I attended the deceased from 8/29, 1957 , to 8/29, 1957 , that I last saw the deceased alive on 8/29, 1957 , and that death occurred at 4:10 AM , from the causes and on the date stated above.		20f. (City or town) (County) (State)
ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE Thomas M. Wilson, M.D.		8/29/57
PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9/3/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State) Suitland, Md. Prince Geo.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Bessie M. Thompson
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE 9-4-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

SEP 6 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08636

CERTIFICATE OF DEATH

08616

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - Kensington</u>				c. LENGTH OF STAY IN 1b <u>18 years</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 rural - Kensington</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3400 Nimitz Road</u>				d. STREET ADDRESS <u>3400 Nimitz Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Helen</u> Last <u>Beltz</u>				4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1874</u>	
9. AGE (In years last birthday) yrs. <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Souders</u>				14. MOTHER'S MAIDEN NAME <u>Jane Slayman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Vivian Shoemaker, 3400 Nimitz Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular-renal disease</u> DUE TO (c) <u>over 20 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11, 1942</u> , to <u>August 29, 1957</u> , that I last saw the deceased alive on <u>August 29, 1957</u> , and that death occurred at <u>7:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3924 Baltimore St., Kensington, Md.</u> DATE SIGNED <u>Aug. 29, 1957</u>							
ACTUAL SIGNATURE <u>Katherine A. Chapman</u> M.D.				NAME (Type) <u>Katherine A. Chapman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Everett Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Everett, Bedford, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>9-4-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

CERTIFICATE OF DEATH

1. PLACE OF DEATH A. HOME		2. SEX M	
3. AGE 65		4. RACE W	
5. DATE OF DEATH SEP 6 1957		6. TIME OF DEATH 10:00 AM	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL	
9. SIGNATURE OF DECEASED [Signature]		10. SIGNATURE OF WITNESS [Signature]	
11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF CORONER [Signature]	
13. SIGNATURE OF BURIAL OFFICIAL [Signature]		14. SIGNATURE OF REGISTRAR [Signature]	
15. SIGNATURE OF VITALS OFFICIAL [Signature]		16. SIGNATURE OF CLERK [Signature]	
17. SIGNATURE OF ASSISTANT CLERK [Signature]		18. SIGNATURE OF CHIEF CLERK [Signature]	
19. SIGNATURE OF DEPUTY CHIEF CLERK [Signature]		20. SIGNATURE OF RECORDS CLERK [Signature]	
21. SIGNATURE OF FILE CLERK [Signature]		22. SIGNATURE OF INDEX CLERK [Signature]	
23. SIGNATURE OF DISTRIBUTION CLERK [Signature]		24. SIGNATURE OF ARCHIVE CLERK [Signature]	
25. SIGNATURE OF RECEPTION CLERK [Signature]		26. SIGNATURE OF DISPATCH CLERK [Signature]	
27. SIGNATURE OF TELETYPE CLERK [Signature]		28. SIGNATURE OF TELEPHONE CLERK [Signature]	
29. SIGNATURE OF MAIL CLERK [Signature]		30. SIGNATURE OF SUPPLY CLERK [Signature]	
31. SIGNATURE OF ACCOUNTS CLERK [Signature]		32. SIGNATURE OF GENERAL CLERK [Signature]	
33. SIGNATURE OF CHIEF OF BUREAU [Signature]		34. SIGNATURE OF DEPUTY CHIEF OF BUREAU [Signature]	
35. SIGNATURE OF ASSISTANT CHIEF OF BUREAU [Signature]		36. SIGNATURE OF CLERK IN CHARGE [Signature]	
37. SIGNATURE OF CLERK IN CHARGE [Signature]		38. SIGNATURE OF CLERK IN CHARGE [Signature]	
39. SIGNATURE OF CLERK IN CHARGE [Signature]		40. SIGNATURE OF CLERK IN CHARGE [Signature]	
41. SIGNATURE OF CLERK IN CHARGE [Signature]		42. SIGNATURE OF CLERK IN CHARGE [Signature]	
43. SIGNATURE OF CLERK IN CHARGE [Signature]		44. SIGNATURE OF CLERK IN CHARGE [Signature]	
45. SIGNATURE OF CLERK IN CHARGE [Signature]		46. SIGNATURE OF CLERK IN CHARGE [Signature]	
47. SIGNATURE OF CLERK IN CHARGE [Signature]		48. SIGNATURE OF CLERK IN CHARGE [Signature]	
49. SIGNATURE OF CLERK IN CHARGE [Signature]		50. SIGNATURE OF CLERK IN CHARGE [Signature]	
51. SIGNATURE OF CLERK IN CHARGE [Signature]		52. SIGNATURE OF CLERK IN CHARGE [Signature]	
53. SIGNATURE OF CLERK IN CHARGE [Signature]		54. SIGNATURE OF CLERK IN CHARGE [Signature]	
55. SIGNATURE OF CLERK IN CHARGE [Signature]		56. SIGNATURE OF CLERK IN CHARGE [Signature]	
57. SIGNATURE OF CLERK IN CHARGE [Signature]		58. SIGNATURE OF CLERK IN CHARGE [Signature]	
59. SIGNATURE OF CLERK IN CHARGE [Signature]		60. SIGNATURE OF CLERK IN CHARGE [Signature]	
61. SIGNATURE OF CLERK IN CHARGE [Signature]		62. SIGNATURE OF CLERK IN CHARGE [Signature]	
63. SIGNATURE OF CLERK IN CHARGE [Signature]		64. SIGNATURE OF CLERK IN CHARGE [Signature]	
65. SIGNATURE OF CLERK IN CHARGE [Signature]		66. SIGNATURE OF CLERK IN CHARGE [Signature]	
67. SIGNATURE OF CLERK IN CHARGE [Signature]		68. SIGNATURE OF CLERK IN CHARGE [Signature]	
69. SIGNATURE OF CLERK IN CHARGE [Signature]		70. SIGNATURE OF CLERK IN CHARGE [Signature]	
71. SIGNATURE OF CLERK IN CHARGE [Signature]		72. SIGNATURE OF CLERK IN CHARGE [Signature]	
73. SIGNATURE OF CLERK IN CHARGE [Signature]		74. SIGNATURE OF CLERK IN CHARGE [Signature]	
75. SIGNATURE OF CLERK IN CHARGE [Signature]		76. SIGNATURE OF CLERK IN CHARGE [Signature]	
77. SIGNATURE OF CLERK IN CHARGE [Signature]		78. SIGNATURE OF CLERK IN CHARGE [Signature]	
79. SIGNATURE OF CLERK IN CHARGE [Signature]		80. SIGNATURE OF CLERK IN CHARGE [Signature]	
81. SIGNATURE OF CLERK IN CHARGE [Signature]		82. SIGNATURE OF CLERK IN CHARGE [Signature]	
83. SIGNATURE OF CLERK IN CHARGE [Signature]		84. SIGNATURE OF CLERK IN CHARGE [Signature]	
85. SIGNATURE OF CLERK IN CHARGE [Signature]		86. SIGNATURE OF CLERK IN CHARGE [Signature]	
87. SIGNATURE OF CLERK IN CHARGE [Signature]		88. SIGNATURE OF CLERK IN CHARGE [Signature]	
89. SIGNATURE OF CLERK IN CHARGE [Signature]		90. SIGNATURE OF CLERK IN CHARGE [Signature]	
91. SIGNATURE OF CLERK IN CHARGE [Signature]		92. SIGNATURE OF CLERK IN CHARGE [Signature]	
93. SIGNATURE OF CLERK IN CHARGE [Signature]		94. SIGNATURE OF CLERK IN CHARGE [Signature]	
95. SIGNATURE OF CLERK IN CHARGE [Signature]		96. SIGNATURE OF CLERK IN CHARGE [Signature]	
97. SIGNATURE OF CLERK IN CHARGE [Signature]		98. SIGNATURE OF CLERK IN CHARGE [Signature]	
99. SIGNATURE OF CLERK IN CHARGE [Signature]		100. SIGNATURE OF CLERK IN CHARGE [Signature]	

BUREAU V. S.

SEP 6 1957

RECEIVED

08637

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mich</u> b. COUNTY <u>Oakland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale 20</u> 59x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>425 W. Woodland Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Blawrock</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <u>Aug 27</u> 19 <u>57</u>	
9. AGE (In years last birthday) <u>27</u> 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTH PLACE (State or foreign country) <u>Ind. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>not given</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Anne Blawrock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Anoxia753.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Fetal Atelectasis

DUE TO

(c) Congenital Cerebral Hypoplasia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

27 hrs. 38 min20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While ☐ Nat while ☐
at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Aug 26, 1957, to Aug 27, 1957, that I last saw the deceased alive on Aug 27, 1957, and that death occurred at 11:30 PM from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

Robert O. WarthenM.D. 3716 Howard Ave., Kens. Md. 8/27/57

PHYSICIAN'S NAME (Type)

Robert O. Warthen3716 Howard Ave., Kensington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert O. Pamphrey</u>		24a. REC'D BY REGISTRAR <u>DATE 9-4-57</u>	
ADDRESS <u>Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 8

SEP 6 1957

RECEIVED

08638

CERTIFICATE OF DEATH

08618

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>11 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>15607 Huntington Parkway</u>			
3. NAME OF DECEASED (Type or print) First <u>Cherry</u> Middle <u>B.</u> Last <u>Bradley</u>				4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/30/07</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>JOSEPH BIBA</u>				14. MOTHER'S MAIDEN NAME <u>EMMA CHESEBRO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MR. HERBERT BRADLEY - HUSBAND.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Papillary Carcinoma of Ovary</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1 Aug 57</u> , 19 <u>57</u> , to <u>19 Aug 57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 Aug 57</u> , 19 <u>57</u> , and that death occurred at <u>12:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>8512005 Georgetown D. B. G. M.D.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>8-22 57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death.

BUREAU V. S.

AUG 26 1957

RECEIVED

08639

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS 1400 29th St., S.E.			
3. NAME OF DECEASED (Type or print) First Thomas Middle Francis Last BREEN				4. DATE OF DEATH Month August Day 28 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 January 1897	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician			10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Patrick BREEN				14. MOTHER'S MAIDEN NAME Mary A. Mc Namara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Sister) Mrs. Mae C. Winter (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Partial Cirrhosis 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from 23 May , 19 57 , to 28 Aug. , 19 57 , that I last saw the deceased alive on 27 Aug. , 19 57 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above. C. U. Shilling ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-28-57 ACTUAL SIGNATURE M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) C. U. SHILLING, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-31-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Bladenburg, Rd., Washington, D.C.				
23. FUNERAL DIRECTOR'S SIGNATURE Costello Funeral Home, 1722 N. Capitol St.,				24a. REC'D BY REGISTRAR DATE 8-28-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 19 1928		MOBILE		ALABAMA		UNITED STATES			
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		MILITARY SERVICE			
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		BUSINESSMAN		ARMY			
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		FILING NO.			
APR 4 1968		MEMPHIS		HEART DISEASE		SUICIDE		100-457611		100-457611		100-457611			
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK			

BUREAU V. 2

AUG 29 1967

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08620

08640

Item 2 Film 0219 9-4-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. 15-56-1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood RFD # 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood RFD # 1 Silver Spring, Rt. # 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Russells Nursing Home		d. STREET ADDRESS Colesville-Smithville Rd. Russells Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George First Brooks Last		4. DATE OF DEATH 8/10/57 Month 8 Day 10 Year 1957	
5. SEX male	6. COLOR OR RACE ool	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/1864
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY lab.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Patrick Brooks (son)		Address Silver Spring, Md. R 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteo-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 012.2 T. B. Rt. Knee 10 yrs.			INTERVAL BETWEEN ONSET AND DEATH 3hrs 5 rs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 8/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 8/14/57	22c. NAME OF CEMETERY OR CREMATORY Round Oak,	22d. LOCATION (City, town, or county) (State) Spencerville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE AUG 14 57
		24b. REGISTRAR'S SIGNATURE Aut...	

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BUREAU V. 3

AUG 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

County of _____

City and State of _____

Decedent's Name _____

Age _____

Sex _____

Occupation _____

Usual Residence _____

Baltimore, Md.

Death Date

Place of Death

08641

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KX. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9810--Ga. Ave. Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Nursing Home				d. STREET ADDRESS 812--Longfellow St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOMA Middle E. Last BROWNING		4. DATE OF DEATH Month Aug. Day 2nd Year 1957		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1878		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oxon Hill, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred B. Baden				14. MOTHER'S MAIDEN NAME Harriet Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Clara E. Harding Address 8312--Carey Lane Silver Springs, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mineralized Interossclerosis 15yrs							INTERVAL BETWEEN ONSET AND DEATH 2wks 10 yrs. 15yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1942 , to August 2, 1957 , that I last saw the deceased alive on August 2, 1957 , and that death occurred at 2:44 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 934 Ellsworth Dr Silver Spring DATE SIGNED 8-2-57							
ACTUAL SIGNATURE Francis B. Daugherty M.D.				PHYSICIAN'S NAME (Type) Silver Spring			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros ADDRESS 1661--Good Hope Rd., S.E. Washington, DC				24a. REC'D BY REGISTRAR AUG 5 1957		24b. REGISTRAR'S SIGNATURE Francis B. Daugherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 5 AUG

RECEIVED

08642

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) V Arlington 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 4836 N. 30th Street			
3. NAME OF DECEASED (Type or print) First Henry Middle Varnum Last BUTLER, IV				4. DATE OF DEATH Month August Day 6 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 March 1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry V. BUTLER, III				14. MOTHER'S MAIDEN NAME Mary BRADLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 9-5-1891 to 4-1-38		16. SOCIAL SECURITY NO. 225-50-9061		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Cerebral Vessels due to Atherosclerosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, Hypostatic Right Lower Lobe 2 August 1957						INTERVAL BETWEEN ONSET AND DEATH 1 August 1957	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1957					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from 1 August , 19 57 , to 6 August , 19 57 , that I last saw the deceased alive on 5 August , 19 57 , and that death occurred at 2:00A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-7-57							
ACTUAL SIGNATURE Thirl Jarrett		M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) THIRL JARRETT, CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9 Aug. 1957	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Savers Sons Qawler's & Sons, 1756 Penn. Ave., N.W. Washington				24a. REC'D BY REGISTRAR DATE 8-6-57		24b. REGISTRAR'S SIGNATURE Mary E. Parnelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 10

BUREAU V. S.

AUG 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08692

CERTIFICATE OF DEATH

08623

Reg. Dist. No.

713

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Haven Rest Home				d. STREET ADDRESS 1 2203 Holly Avenue 7203			
3. NAME OF DECEASED (Type or print) First GRACE Middle Byrn Last 7203				4. DATE OF DEATH Month August Day 2 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Patent Office		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Washington Hakesley				14. MOTHER'S MAIDEN NAME Mary E. Bandel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Harriett Stirling-7203 Holly Ave. Takoma Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure DUE TO (c) hypertensive heart disease						INTERVAL BETWEEN ONSET AND DEATH immediate 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 12 1957 to Aug 1 1957 that I last saw the deceased alive on Aug 1 1957 , and that death occurred at 1220 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3100 Conn Ave DATE SIGNED Aug 6 1957							
ACTUAL SIGNATURE John V. Dolan M.D.				PHYSICIAN'S NAME (Type) John V. Dolan 3100 Conn. Ave., N.W., Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/1957		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W. DC				24. REC'D BY REGISTRAR AUG 6 1957			
				25. REGISTRAR'S SIGNATURE John Wilson			

CERTIFICATE OF DEATH

Form No. 1

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
COUNSELOR		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		5' 10"		160	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		PREVIOUS ILLNESS	
HEART DISEASE		SUICIDE		2 WEEKS		PAIN IN CHEST		NO		NO		NO		NO	
PHYSICIAN		HOSPITAL		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
DR. JAMES EARL RAY		HOSPITAL		JAN 6 1968		10:00 PM		HOSPITAL		BALTIMORE		MARYLAND		UNITED STATES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
AUG 6 1967
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08624	
Item 3: phone call 9-4-57 from informant, L.										Reg. Dist. No. 216	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS <u>16813 Wilson Lane</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK LYNN CARTER</u>					4. DATE OF DEATH <u>Aug. 17 1957</u>		Month <u>Aug.</u> Day <u>17</u> Year <u>1957</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Club mgr.</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Walter Frank Carter</u>					14. MOTHER'S MAIDEN NAME <u>Arabella Hedley</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frank L. Carter Jr.</u>		Address <u>6813 Wilson Lane Bethesda</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Cardiovascular Disease</u> DUE TO (c) <u>Rheumatic fever</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>7-1-1957</u> , to <u>8-17-1957</u> , that I last saw the deceased alive on <u>8-17-1957</u> , and that death occurred at <u>1:55 AM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Russell M. Tilley, D.</u>					ADDRESS (Street, city or town, state) <u>4701 Mass Ave NW Wash. 16 D.C.</u>					DATE SIGNED <u>8-17-57</u>	
PHYSICIAN'S NAME (Type) <u>Russell M. Tilley</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>8/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chantrel Home</u>					ADDRESS <u>5103 14th St. NW</u>		24a. REC'D BY REGISTRAR <u>DATE 8-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>		

MEDICAL CERTIFICATION

BUREAU

[illegible]

BUREAU V. S.

1957 23 AUG

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08644

CERTIFICATE OF DEATH

08625

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 H ours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Woodbine		d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery Co, General Hosp,	
d. STREET ADDRESS 13x12		e. IS RESIDENCE ONLY FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) C OMUS First Middle Last CHR OBOT		4. DATE OF DEATH Month August Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb, 17 1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 21 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawernee Chrobot		14. MOTHER'S MAIDEN NAME Katie Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W.		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Elsie V. Chrobot		Address Woodbine, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 Sestric hemorrhage DUE TO (b) Peptic ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 12 hours 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 2 - , 1951 to August 21, 1957 , that I last saw the deceased alive on August 21, 1957 , and that death occurred at 8:50 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		DATE SIGNED 8/31/57	
PHYSICIAN'S NAME (Type) JAMES P-KERR M.D.		ADDRESS (Street, city or town, state) DAMASCUS, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 24	22c. NAME OF CEMETERY OR CREMATORY Jennings Chapel	22d. LOCATION (City, town, or county) (State) Jennings Chapel, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rayw Barber		24a. REC'D BY REGISTRAR DATE 8-23-57	
ADDRESS Laytonsville. Md.		24b. REGISTRAR'S SIGNATURE Arthur B Lawler	

CERTIFICATE OF DEATH

DECEASED JAMES W. WOODWARD		MARRIED MARY ANN WOODWARD	
PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF BIRTH BALTIMORE, MARYLAND	
DATE OF BIRTH JANUARY 17, 1889		DATE OF BIRTH JANUARY 17, 1889	
SEX MALE		SEX FEMALE	
RACE WHITE		RACE WHITE	
OCCUPATION UNKNOWN		OCCUPATION UNKNOWN	
PLACE OF DEATH BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND	
DATE OF DEATH AUGUST 29, 1957		DATE OF DEATH AUGUST 29, 1957	
TIME OF DEATH 11:15 A.M.		TIME OF DEATH 11:15 A.M.	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN JAMES W. WOODWARD		SIGNATURE OF PHYSICIAN JAMES W. WOODWARD	
SIGNATURE OF WITNESS JAMES W. WOODWARD		SIGNATURE OF WITNESS JAMES W. WOODWARD	

BUREAU W.S.

AUG 29 1957

RECEIVED

08645

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Kentucky b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madisonville 55x-3			
d. STREET ADDRESS 156 North Seminary Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Omer Middle Daniel Last Clayton				4. DATE OF DEATH Month August Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 27, 1931	
9. AGE (In years last birthday) 25		IF UNDER 1 YEAR Months 9 Days 21		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Omer T. Clayton				14. MOTHER'S MAIDEN NAME Bonnie Bowles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean				16. SOCIAL SECURITY NO. Not available			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INCREASED INTRACRANIAL PRESSURE 190x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC MALIGNANT MELANOMA DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 30 , 19 57 , to August 18 , 19 57 ; that I last saw the deceased alive on August 18 , 19 57 , and that death occurred at 2:30 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/18/57 ACTUAL SIGNATURE Richard K. Shaw M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Bur-transit		8/19/1957		Browders Cem.		Hopkins Co. Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR 8-22-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATEMENT OF HEALTH - BALTIMORE, 19

BUREAU V. S.

AUG 26 1957

RECEIVED

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		MAY 14 1968	
AGE		SEX	
35		Male	
RACE		EDUCATION	
White		High School	
BIRTH DATE		BIRTH PLACE	
JAN 5 1933		MOBILE, ALABAMA	
MARRIAGE DATE		MARRIAGE PLACE	
-		-	
OCCUPATION		CAUSE OF DEATH	
Actor		Suicide	
RESIDENCE		PLACE OF DEATH	
150 North Broadway Street		Baltimore, Maryland	
DATE OF INTERVIEW		INTERVIEWER	
MAY 15 1968		JAMES EARL RAY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
James Earl Ray		James Earl Ray	
DATE OF SIGNATURE		DATE OF SIGNATURE	
MAY 14 1968		MAY 14 1968	

08646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia c. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 303 Hamilton Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Wayne Middle Allen Last Clift		4. DATE OF DEATH		Month August Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 9, 1954		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Cline A. Clift				14. MOTHER'S MAIDEN NAME Eroll Hutchins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 754.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Patent ductus arteriosus DUE TO (c) Congenital						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 4, 1957 , to August 21, 1957 , that I last saw the deceased alive on August 21, 1957 , and that death occurred at 4:40p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center Bethesda 14, Maryland 8/21/57							
ACTUAL SIGNATURE James A. McFarland M.D.				PHYSICIAN'S NAME (Type) James A. McFarland, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug. 26-57		22b. DATE THEREOF Aug. 26-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) St. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Demaine Jr.				24a. REG. DIST. REGISTRAR AUG 26 1957			
ADDRESS Alex. Va.				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

AUG 26 1957

RECEIVED

08647

CERTIFICATE OF DEATH

Reg. Dist. No. 2 08628

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>12726-Washington Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jenny</u> Middle <u>R.</u> Last <u>Cohen</u>				4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1869</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Nathan Dennison</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Salgaller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HARRY H. Cohen - SON; 2726-Wash. Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>20 years</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Bladder</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>August 3, 1957</u> , that I last saw the deceased alive on <u>August 3, 1957</u> , and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>Milton Gusack</u>				M.D. <u>1302-18th St. N.W. Wash. 8/3/57</u>			
PHYSICIAN'S NAME (Type) <u>Milton Gusack, M.D.</u>				D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>8/4/57</u>		<u>Wash. Hebrew Cong.</u>		<u>D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shelley K. K... 4217-9th Ave</u>				24a. REC'D BY REGISTRAR DATE <u>8-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint, illegible handwriting.

BUREAU V. B.

AUG 7 1957

RECEIVED

CERTIFICATE OF DEATH

08629

Reg. Dist. No. 223

08693

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Senr Hosp</u>				d. STREET ADDRESS <u>2214 Prichard Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Ann Coleman</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 23 19 57</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/8/1905</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-Typist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DC</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>John Gorman</u>				14. MOTHER'S MAIDEN NAME <u>Carolyn Ganz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-32-4539</u>		17. INFORMANT Address <u>Mrs. Leonard E. Johnson, 2214 Prichard Rd. Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT - HEMORRHAGE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>NONE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>8-23</u> , 19 <u>57</u> to <u>8-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-23</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Henry W. Stout MD.</u> M.D. <u>10011 GEORGIA AVE</u> <u>8-23-57</u> <u>SILVER SPRING, MARYLAND</u> PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thorne E. Pumpfrey</u> ADDRESS <u>8454 Lake 55 Rd.</u>				24a. REC'D BY REGISTRAR <u>John A. Dodd</u> DATE <u>8/26/57</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
JOHN J. JONES		M		45		W		JUL 27 1957		10:30 AM		HOME		HEART DISEASE		NATURAL		J. J. JONES		J. J. JONES		J. J. JONES	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. PLACE OF DEATH		16. DATE OF DEATH		17. PLACE OF DEATH		18. DATE OF DEATH		19. PLACE OF DEATH		20. DATE OF DEATH		21. PLACE OF DEATH		22. DATE OF DEATH		23. PLACE OF DEATH		24. DATE OF DEATH	
BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957	
19. PLACE OF BIRTH		20. DATE OF BIRTH		21. PLACE OF DEATH		22. DATE OF DEATH		23. PLACE OF DEATH		24. DATE OF DEATH		25. PLACE OF DEATH		26. DATE OF DEATH		27. PLACE OF DEATH		28. DATE OF DEATH		29. PLACE OF DEATH		30. DATE OF DEATH	
BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957		BALTIMORE, MD		JUL 27 1957	

RECEIVED
JUG 27 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

08630 2/16

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 hour 25 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 137 Choctaw	
3. NAME OF DECEASED (Type or print) First Marie Middle Ann Last Collier		4. DATE OF DEATH Month August Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 May 1924
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician		12. KIND OF BUSINESS OR INDUSTRY Government	
13. BIRTHPLACE (State or foreign country) Washington, D.C.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Charles F. Kidwell		16. MOTHER'S MAIDEN NAME Sarah Cornell	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 579-22-2660	
19. INFORMANT The Medical Record		20. ADDRESS The Clinical Center, Bethesda 14, Maryland	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease with mitral and tricuspid stenosis; post-mitral commissurotomy DUE TO 1956 (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		23b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
24a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24b. (City or town) (County) (State)	
25. I certify that I attended the deceased from 27 August , 19 57 , to 27 August , 19 57 , that I last saw the deceased alive on 27 August , 19 57 , and that death occurred at 10:00A , from the causes and on the date stated above.			
ACTUAL SIGNATURE James A. McFarland		DATE SIGNED 8/27/57	
PHYSICIAN'S NAME (Type) James A. McFarland, M. D.		ADDRESS (Street, city or town, state) The National Institutes of Health The Clinical Center Bethesda 14, Maryland	
26a. BURIAL, CREMATION, REMOVAL (Specify) Burial	26b. DATE THEREOF Aug. 30, 57	26c. NAME OF CEMETERY OR CREMATORY Arlington, Natl.	26d. LOCATION (City, town, or county) (State) Arlington, Va.
27. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		28. REC'D BY REGISTRAR AUG 29 1957	
ADDRESS 517-11th St. S.E.		REGISTRAR'S SIGNATURE Kessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1957		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Education		Religion		Race		Color		Manner of Death		Certified by		Date of Certification		Place of Certification		Signature of Physician		Signature of Registrar	
Teacher		Married		High School		Roman Catholic		White		White		Natural		J. Doe, M.D.		Jan 15, 1957		Baltimore, Md.		J. Doe, M.D.		J. Doe, M.D.	
Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

RECEIVED
AUG 29 1957
BUREAU V. S.

08643

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,		c. LENGTH OF STAY IN 1b 29 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonard Middle Manning Last Celipitts		4. DATE OF DEATH Month AUG. Day 17, Year 1957	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1866
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former - RETIRED.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? Canada	
13. FATHER'S NAME David Harris		14. MOTHER'S MAIDEN NAME Frances Mollins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Ida M Cleveland	
17. INFORMANT Address Ida M Cleveland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Carcinoma of Urinary Bladder 181X DUE TO with terminal uremia and pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) and pyelonephritis (c) and pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH 3 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5:00 , 1953, to Aug 17 , 1957, that I last saw the deceased alive on Aug 17 , 1957, and that death occurred at 5:10 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St N.W. Wash 15 D.C. DATE SIGNED Aug 17 '57			
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St N.W. Wash 15 D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 8-18-57	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Shirley Village Cem.	22d. LOCATION (City, town, or county) (State) Middlesex Co., Mass.
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Langley		ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR DATE 8-22-57
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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72, 71, 70.

BUREAU V. S.

AUG 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08632

08650

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b 10 years				d. STREET ADDRESS 9500 Seminole Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9500 Seminole Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edgington Franklin Combes				4. DATE OF DEATH Month Day Year August 29 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1901 June 17, 1957	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Agent				10b. KIND OF BUSINESS OR INDUSTRY Brokerage		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Perrea M. Combes				14. MOTHER'S MAIDEN NAME Dora Franklin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address Gertrude H. Combes 9500 Seminole Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Central aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central Thrombosis DUE TO (c) Central Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 15 min 30 min Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov 7, 1957 , to 8/29/57 , that I last saw the deceased alive on 8/29/57 , and that death occurred at 2:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen H. Jones M.D.				ADDRESS (Street, city or town, state) Rockville, Md			
DATE SIGNED 8/29/57							
PHYSICIAN'S NAME (Type) Stephen H. Jones, M.D.				809 Viers Mill Rd, Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey				ADDRESS Silver Spring, Md		24a. REC'D BY REGISTRAR 8/30/57	
24b. REGISTRAR'S SIGNATURE Francis Deller							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>NAME OF DECEASED Silver Spring</p>		<p>DATE OF DEATH 10 years</p>	
<p>RESIDENCE 9500 Seminoles Road</p>		<p>PLACE OF DEATH Silver Spring</p>	
<p>DATE OF BIRTH June 14, 1907</p>		<p>AGE 50</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>GENERAL AVAIL Brokers</p>		<p>ILLINOIS</p>	
<p>DATE OF BIRTH Born</p>		<p>PLACE OF BIRTH U.S.A.</p>	
<p>NAME OF DECEASED Gordon W. Gordon</p>		<p>DATE OF DEATH Yes</p>	
<p>RESIDENCE 800 View Hill Rd.</p>		<p>PLACE OF DEATH Silver Spring</p>	
<p>DATE OF BIRTH 1907</p>		<p>AGE 50</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>GENERAL AVAIL Brokers</p>		<p>ILLINOIS</p>	
<p>DATE OF BIRTH Born</p>		<p>PLACE OF BIRTH U.S.A.</p>	
<p>NAME OF DECEASED Gordon W. Gordon</p>		<p>DATE OF DEATH Yes</p>	
<p>RESIDENCE 800 View Hill Rd.</p>		<p>PLACE OF DEATH Silver Spring</p>	
<p>DATE OF BIRTH 1907</p>		<p>AGE 50</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>GENERAL AVAIL Brokers</p>		<p>ILLINOIS</p>	
<p>DATE OF BIRTH Born</p>		<p>PLACE OF BIRTH U.S.A.</p>	

RECEIVED
SEP 3 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08633
Item 18 Film 219 8-16-57 ams										08651
CERTIFICATE OF DEATH										Reg. Dist. No. 215
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Rhode Island b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newport 76X-3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.					d. STREET ADDRESS 56 Levin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last COX					4. DATE OF DEATH Month August Day 2 Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 August 1908		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner			10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Tennessee			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William COX					14. MOTHER'S MAIDEN NAME Lydia CHADWELL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma DUE TO Gastric Carcinoma (c) (Adenocarcinoma of Stomach)								INTERVAL BETWEEN ONSET AND DEATH 1 mo. 6 mo.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 25 July , 19 57 , to 2 August , 19 57 , that I last saw the deceased alive on 1 August , 19 57 , and that death occurred at 7:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED										
ACTUAL SIGNATURE Douglas R. Koth				M.D. U.S. Naval Hospital, Bethesda, Md. 8-2-57						
PHYSICIAN'S NAME (Type) Douglas R. Koth, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-57		22c. NAME OF CEMETERY OR CREMATORY Island Cemetery			22d. LOCATION (City, town, or county) (State) Newport, Rhode Island			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave.,				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 8-2-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly		

BUREAU V. S.

1957. 6. 5

RECEIVED

08652 CERTIFICATE OF DEATH

08634

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 7 mos. 12 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3				d. STREET ADDRESS 2500 Wisconsin Ave., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Conrad Middle Winfield Last CRAVEN				4. DATE OF DEATH Month August Day 14 Year 19 57			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 October 1909	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Wesley CRAVEN				14. MOTHER'S MAIDEN NAME Ina TRUSTY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Currently				16. SOCIAL SECURITY NO. 576-10-7337		17. INFORMANT (Wife) Mrs. Darleen F. CRAVEN (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, right lung - metastasized 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2 Jan. , 19 57 , to 14 August , 19 57 , that I last saw the deceased alive on 14 August , 19 57 , and that death occurred at 3:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 8-15-57							
ACTUAL SIGNATURE D.P. Osborne				M.D. U.S. Naval Hospital, Bethesda, Md. 8-15-57			
PHYSICIAN'S NAME (Type) D.P. OSBORNE, CAPT. MC, USN				ADDRESS U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8-16-57		Arlington Nat'l Cemetery		Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumpfrey				ADDRESS 1557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 8-15-57	
24b. REGISTRAR'S SIGNATURE May E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 19. 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08604

CERTIFICATE OF DEATH

Reg. Dist. No. 086353

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>DC.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sent Hosp.</i>				d. STREET ADDRESS <i>2301 Conn ave N.W.</i>			
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>Harland</i> Last <i>Crowell</i>				4. DATE OF DEATH Month <i>8</i> - Day <i>3</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/29/85</i>	9. AGE (In years last birthday) <i>71</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>PQ</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Elisha Crowell</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Harland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Infarction</i> DUE TO (c) <i>Generalized Arteriosclerosis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i> <i>9 days</i> <i>?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>7-27-1957</i> , to <i>8-3-1957</i> , that I last saw the deceased alive on <i>8-3-1957</i> , and that death occurred at <i>8:45 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert A. Hare</i>				ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i> DATE SIGNED <i>8/4/57</i>			
PHYSICIAN'S NAME (Type) <i>Robert A. HARE</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 7, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Company</i>				ADDRESS <i>Washington, D. C.</i>		24a. REC'D BY REGISTRAR <i>Aug 6 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. Wilson Ladd</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		White		April 22, 1928		Memphis, Tennessee		April 4, 1968		Nashville, Tennessee		Gunshot wound		Homicide		[Signature]		[Signature]		[Signature]		[Signature]	
15. OCCUPATION		16. EDUCATION		17. MARITAL STATUS		18. RELIGION		19. PREVIOUS ILLNESS		20. PREVIOUS SURGERY		21. PREVIOUS TRAUMA		22. PREVIOUS DRUGS		23. PREVIOUS ALCOHOL		24. PREVIOUS TOBACCO		25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER	
Attorney		High School		Married		Catholic		None		None		None		None		None		None		None		None		None		None	
29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER		37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	
43. PREVIOUS OTHER		44. PREVIOUS OTHER		45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER		49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER		56. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	
57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER		61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER		65. PREVIOUS OTHER		66. PREVIOUS OTHER		67. PREVIOUS OTHER		68. PREVIOUS OTHER		69. PREVIOUS OTHER		70. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	
71. PREVIOUS OTHER		72. PREVIOUS OTHER		73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER		77. PREVIOUS OTHER		78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER		81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	
85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER		89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER		93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER		97. PREVIOUS OTHER		98. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	
99. PREVIOUS OTHER		100. PREVIOUS OTHER		101. PREVIOUS OTHER		102. PREVIOUS OTHER		103. PREVIOUS OTHER		104. PREVIOUS OTHER		105. PREVIOUS OTHER		106. PREVIOUS OTHER		107. PREVIOUS OTHER		108. PREVIOUS OTHER		109. PREVIOUS OTHER		110. PREVIOUS OTHER		111. PREVIOUS OTHER		112. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	

RECEIVED
AUG 6 1967
BUREAU V. S.

TO BE FILLED BY THE REGISTRAR
1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. DATE OF DEATH
8. PLACE OF DEATH
9. CAUSE OF DEATH
10. MANNER OF DEATH
11. SIGNATURE OF PHYSICIAN
12. SIGNATURE OF REGISTRAR
13. SIGNATURE OF WITNESSES
14. SIGNATURE OF DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08653

CERTIFICATE OF DEATH

08636

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brinklow</u> x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. General Hospital, Inc.</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Cuff</u>				4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/1/85</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman, District Water</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Department</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>William Cuff</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hewitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-18-1801</u>		17. INFORMANT <u>Alice M. Cuff</u> Address <u>Brinklow, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Artemia</u> <u>446x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>6 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular accident 3 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>Aug 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 12</u> , 19 <u>57</u> , and that death occurred at <u>2:40 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.							
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D.</u>				<u>Clarksville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brinklow, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber, Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>8-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08637

08654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>	c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 28 - R.F.D. #2</u>		d. STREET ADDRESS <u>1 Route 28 - R.F.D. #2</u>	
3. NAME OF DECEASED (Type or print) <u>Jeffrey Donohue Cunningham</u>		4. DATE OF DEATH <u>8-11-57</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/57</u>
9. AGE (In years last birthday) <u>1</u> yrs. <u>3</u> Months <u>3</u> Days		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tinsley Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Bertram Jean Balbridge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of larynx</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> DUE TO (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>8/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>West Palm Beach, Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>AUG 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Alberda Cook</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2174325XV2

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Place of Birth: [illegible]
6. Date of Death: [illegible]
7. Place of Death: [illegible]
8. Cause of Death: [illegible]
9. Manner of Death: [illegible]
10. Signature of Medical Examiner: [illegible]
11. Signature of Coroner: [illegible]
12. Signature of Physician: [illegible]

BUREAU V. 3.

AUG 21 1957

RECEIVED

Transmit 8/23/57

Robert A. Humphrey - Bethesda, Md.

CERTIFICATE OF DEATH

08638

Reg. Dist. No.

223

08605

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u>		d. STREET ADDRESS <u>1607 Neeley Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVEY</u>		4. DATE OF DEATH Month Day Year <u>aug. 28 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>aug 29 - 57</u>
9. AGE (In years lost birthday) yrs. <u>30</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>30 6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ralph Phillip Davey</u>		14. MOTHER'S M maiden NAME <u>Shirley Margaret Kelley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Incomplete Expansion of lungs/</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 27</u> , 19 <u>57</u> , to <u>Aug. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 28</u> , 19 <u>57</u> , and that death occurred at <u>6:15</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		<u>9301 Colesville Rd. Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>8-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp; Takoma Park, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. Ke</u>		ADDRESS <u>Wash. San. & Hosp.</u>	
24a. REC'D BY REGISTRAR <u>8/31/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. F. H. Hare</u>	

2175333XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1
FOR STATE
HEALTH DEPT.

08655 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

08639

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u> x2 <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5204 Flanders Ave</u>		d. STREET ADDRESS <u>15204 Flanders Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Simeon Dayton</u>		4. DATE OF DEATH <u>8-11-57</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-04</u> 53 yrs.
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Training Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N. I. H.</u>	
11. BIRTHPLACE (State or foreign country) <u>N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles F. Dayton</u>		14. MOTHER'S MARRIAGE NAME <u>Flora Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW11</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>WW11</u>	
17. INFORMANT <u>Ruth Dayton (wife)</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>8-14-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bruce M. Thompson</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *Robert A. Murphy*
2. Date of Death: *8-14-57*
3. Place of Death: *Home*
4. Age: *30*
5. Sex: *M*
6. Race: *W*
7. Occupation: *Business*
8. Cause of Death: *Heart Disease*
9. Manner of Death: *Natural*
10. Signature of Examiner: *[Signature]*
11. Date of Certificate: *8-14-57*

RECEIVED
AUG 19 1957
BUREAU V. S.

Robert A. Murphy - Business, Maryland
8/14/57
Butler

08656

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland b. COUNTY aa			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 0210.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 235 Fig Road			
3. NAME OF DECEASED (Type or print) First Linda Middle Jean Last DEAR				4. DATE OF DEATH Month August Day 18 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 January 1955	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Russell DEAR				14. MOTHER'S MAIDEN NAME June Edith PERT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Russell Dear, (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) EMBRYOMA, MALIGNANT OF KIDNEY WITH METASTASES							INTERVAL BETWEEN ONSET AND DEATH 8 1/2 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 24 July , 19 57 , to 18 Aug. , 19 57 , that I last saw the deceased alive on 18 August , 19 57 , and that death occurred at 9:19 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Russell Miller, Jr.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 8-19-57							
PHYSICIAN'S NAME (Type) Russell Miller, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-57		22c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		22d. LOCATION (City, town, or county) (State) New York, New York	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR 8-19-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08641

08657

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8218 Tahona Drive		d. STREET ADDRESS 8218 Tahona Drive	
3. NAME OF DECEASED (Type or print) First E Middle HEWITT Last DIMMITT		4. DATE OF DEATH Month 8 Day 31 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/16/1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect- Draftsman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Birmingham, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy Dimmitt		14. MOTHER'S MAIDEN NAME Esther H. ----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes [If yes, give war or dates of service] W.W.II		16. SOCIAL SECURITY NO. 215-26-2439	
17. INFORMANT Mrs. Kathrynne Dimmitt		Address 8218 Tahona Dr. Silver Spring Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Phenyls Heart Disease DUE TO (c) 104 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 52 to Aug 31, 1957 , that I last saw the deceased alive on Aug 17, 1957 , and that death occurred at 5:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1019 University Boulevard East-S.S.Md. DATE SIGNED 8/31/57			
ACTUAL SIGNATURE Boris Rabkin		M.D. 1019 University Boulevard East-S.S.Md.	
PHYSICIAN'S NAME (Type) Boris Rabkin		1019 University Blvd., East-S.S.Md.	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 9/3/1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR SEP 3 1957	
24b. REGISTRAR'S SIGNATURE James Potter			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

Key fields visible (reading from top to bottom):

- NAME OF DECEASED
- DATE OF DEATH
- PLACE OF DEATH
- CAUSE OF DEATH
- DATE OF BIRTH
- PLACE OF BIRTH
- SEX
- RACE
- EDUCATION
- OCCUPATION
- RELIGION
- DATE OF MARRIAGE
- PLACE OF MARRIAGE
- DATE OF DEATH (repeated)
- PLACE OF DEATH (repeated)
- CAUSE OF DEATH (repeated)
- DATE OF BIRTH (repeated)
- PLACE OF BIRTH (repeated)
- SEX (repeated)
- RACE (repeated)
- EDUCATION (repeated)
- OCCUPATION (repeated)
- RELIGION (repeated)
- DATE OF MARRIAGE (repeated)
- PLACE OF MARRIAGE (repeated)

EAU Y. L.

EP 3 1957.

RECEIVED

08658

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08642

Reg. Dist. No. 214

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12226 Center Hill St.</u>				d. STREET ADDRESS <u>12226 Center Hill St</u>			
3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>Mooney</u> Last <u>Dunlap</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1885</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Pan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Mooney</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Anthony E. Dunlap</u>		Address <u>Stem # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (a), stalling the underlying cause lost. DUE TO (c) <u>10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-19-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Forest Glen, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Humphrey</u>				24a. REC'D BY REGISTRAR DATE <u>8/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Peller</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. R.

AUG 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08659

Item 7 FilmG219 8-30-57 et

CERTIFICATE OF DEATH

08643

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Echison				c. LENGTH OF STAY IN 1b 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Echison	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R F D 2 Gaithersburg, Md.				d. STREET ADDRESS R F D 2 Gaithersburg		e. IS RESIDENCE ONLY FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NETTIE First HAMMOND Middle DUVALL Last				4. DATE OF DEATH August Month 19 Day 57 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Married DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Osborn Echison				14. MOTHER'S MAIDEN NAME Mary Virginia Penn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not, or not known) ###		16. SOCIAL SECURITY NO. (If yes, date of service) #####		17. INFORMANT Ollie B. Duvall		Address Same As 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 10 years							INTERVAL BETWEEN ONSET AND DEATH 6 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. j. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 2 , 19 52 to August 19 , 19 57 , that I last saw the deceased alive on August 18 , 19 57 , and that death occurred at 2 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr M.D.				ADDRESS (Street, city or town) state Damascus, Md. DATE SIGNED 8/20/57			
PHYSICIAN'S NAME (Type) JAMES P. KERR M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug, 21 57		22c. NAME OF CEMETERY OR CREMATORY Damascus Cent.		22d. LOCATION (City, town, or county) (State) Damascus Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber ADDRESS Lattonsville, Md.				24a. REC'D BY REGISTRAR DATE Aug 22/57		24b. REGISTRAR'S SIGNATURE Della W. Burdette	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Reg. No. 10

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BUREAU V. S.

AUG 26 1957

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08606

CERTIFICATE OF DEATH

086443

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u> 16252	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium and Hosp. Ltd.</u>		d. STREET ADDRESS <u>4900 TUCKERMAN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy SAMUEL EDWARDS</u>		4. DATE OF DEATH <u>August 29 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/57</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>10</u> Hours <u>26</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE - INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Edwin Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Alice Dunn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or date of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>SAMUEL E. EDWARDS</u>		Address <u>4900 TUCKERMAN ST. Riverdale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 1957	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Aug 24</u> 1957, to <u>Aug 29</u> 1957, that I last saw the deceased alive on <u>Aug 29</u> 1957, and that death occurred at <u>11:27 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Ruth Standard</u> M.D. <u>Wash. San. Hosp. - Aug 30 1957</u> PHYSICIAN'S NAME (Type) <u>Ruth Standard - M.D.</u> <u>Takoma Park Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Pk 600 Co. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Chambers Co - Riverdale, Md.</u>		24. REG'D BY REGISTRAR <u>SEP 5 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. M. B. B.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075411XV2

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE		OCCUPATION	
JAMES EARL RAY		APRIL 14, 1928		MALE		WHITE		MARRIED		PASTOR	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENNESSEE		APRIL 4, 1968		10:00 AM		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL	
EDUCATION		RELIGION		SPECIAL OCCASION		PREVIOUS ILLNESS		TREATMENT		POSTMORTEM	
HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE	
FAMILY HISTORY		SOCIAL HISTORY		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO		HISTORY OF OTHER	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF OTHER	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE		DATE		DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. 2

SEP 5 1957

RECEIVED

08607

CERTIFICATE OF DEATH

08645

Reg. Dist. No.

7/23

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San. Hospital</u>		d. STREET ADDRESS <u>7216 - 7th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Loreena Epperson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTH PLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John M. Elsea</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret L. Miles</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Wash. San. Hosp. Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of colon-rectum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic involving spinal bone</u> DUE TO (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> 19 <u>55</u> to <u>Aug 2</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 2</u> 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>500 N. Underwood St. Washington, D. C.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Chas H. Wolton</u> M.D.		PHYSICIAN'S NAME (Type) <u>Chas H. Wolton</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Heins Co</u> ADDRESS <u>2901 14th St N.W.</u>		24a. REC'D BY REGISTRAR <u>5</u> 1957 24b. REGISTRAR'S SIGNATURE <u>Wilson Duddy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08660

CERTIFICATE OF DEATH

08646

Reg. Dist. No.

2/7

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b 3 hrs. 2 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS Route #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Evans				4. DATE OF DEATH Month August Day 10 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/57		9. AGE (In years lost birthday) yrs. 3	IF UNDER 1 YEAR Months 3 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Martin Evans				14. MOTHER'S MAIDEN NAME Hester Livesay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address Sandy Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intercranial hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 10, 1957 to Aug 10, 1957 , that I last saw the deceased alive on Aug 10, 1957 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles S. Whitaker				ADDRESS (Street, city or town, state) CLARKSVILLE, MD.		DATE SIGNED 8/10/57	
PHYSICIAN'S NAME (Type) Dr. C. S. Whitaker							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-12-57		22c. NAME OF CEMETERY OR CREMATORY Seale		22d. LOCATION (City, town, or county) (State) Smithsburg Rt. 2, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Burke A. Hight - Clarksville, Md.				ADDRESS Clarksville, Md.		24a. REC'D BY REGISTRAR DATE 8-11-57	
				24b. REGISTRAR'S SIGNATURE Gertrude L. Lashley			

2073201XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08661

CERTIFICATE OF DEATH

08647
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700 Hudson Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 8621 Piney Branch Road							
3. NAME OF DECEASED (Type or print) First ROSE Middle MARY Last FENWICK				4. DATE OF DEATH Month August Day 27 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/15/1899	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min. 58		IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Benedict Fenwick				14. MOTHER'S MAIDEN NAME Katherine Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Yes		17. INFORMANT Mr. Hanson Fenwick 2018 Quantico Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175x Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of left ovary with metastases DUE TO (c) 4 1/2 years				INTERVAL BETWEEN ONSET AND DEATH 30 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Silver Spring				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from 12 Aug. , 19 55 , to 27 Aug. , 19 57 , that I last saw the deceased alive on 19 Aug. , 19 57 , and that death occurred at 9:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Seruch T. Kimble				ADDRESS (Street, city or town, state) 929 Pershing Dr., Silver Spring, Md.			
DATE SIGNED 27 Aug 1957							
PHYSICIAN'S NAME (Type) Seruch T. Kimble				ADDRESS 929 Pershing Dr., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/57		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Forest Glen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring		24. REC'D BY REGISTRAR Ma	
25. REGISTRAR'S SIGNATURE Helm				26. REGISTRAR'S SIGNATURE Helm		27. REGISTRAR'S SIGNATURE Helm	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DECEMBER 1996

U.S. Navy . . . 2.0

John C. O'Neil

AUG 30 1957

RECEIVED

08608

CERTIFICATE OF DEATH

08648

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Rosetta</u> Last <u>Fichter</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/14/84</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Fichter</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rye</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT Address <u>6807 Allegheny</u> <u>Brother George T. Fichter JR. Ph. Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Congestive failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic coma</u> DUE TO (c) <u>Cellulitis, left forearm</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 28, 1957</u> , to <u>Aug 30, 1957</u> , that I last saw the deceased alive on <u>Aug 30, 1957</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eino Magi</u>				ADDRESS (Street, city or town, state) <u>918 University Blvd. East, Silver Spring, Md.</u>			
DATE SIGNED <u>9/3/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William D. Hall</u> ADDRESS <u>254 Carroll St NW D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>William D. Hall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGISTRATION NO.

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIED		SINGLE	
BORN		DIED	
CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF BURIAL		DATE OF BURIAL	
SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED	

Can't find

100-100000

100-100000

100-100000

BUREAU V. S.

SEP 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G220 9-24-57 et
08662
CERTIFICATE OF DEATH

08649

Reg. Dist. No.

217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Baltimore Road (Private home)</u>		d. STREET ADDRESS <u>802 Eye St. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Joseph</u> Last <u>Flynn</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1883</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Patrick J. FLYNN</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Gannon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James D. Flynn</u> Address <u>Washington 21, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration and Asphyxia</u> 157X DUE TO <u>Carcinoma of Head of Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1-2 yrs.</u> (c) <u>1-2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 27</u> , 19 <u>57</u> , to <u>Aug 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 27</u> , 19 <u>57</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Olney Md</u> DATE SIGNED <u>8/27/57</u> ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D. PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-31-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon - 3831-G.O. Ave. N.W.</u> ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Gertrude Lindsey</u>	
24a. REC'D BY REGISTRAR <u>29 1957</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No. 18

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. RACE <i>White</i>		4. DATE OF BIRTH <i>Jan 1, 1900</i>		5. PLACE OF BIRTH <i>City of Baltimore, Md.</i>	
6. DATE OF DEATH <i>Aug 29, 1957</i>		7. PLACE OF DEATH <i>City of Baltimore, Md.</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>		10. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
11. SIGNATURE OF DECEASED <i>[Signature]</i>		12. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		13. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		14. SIGNATURE OF MORTUARY <i>[Signature]</i>		15. SIGNATURE OF BURIAL <i>[Signature]</i>	
16. SIGNATURE OF CLERK <i>[Signature]</i>		17. SIGNATURE OF CHURCH <i>[Signature]</i>		18. SIGNATURE OF CEMETERY <i>[Signature]</i>		19. SIGNATURE OF FUNERAL HOME <i>[Signature]</i>		20. SIGNATURE OF OTHER <i>[Signature]</i>	

BUREAU Y. S.

AUG 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08650

08663

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Montgomery b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b 12 hrs. 45 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS Clarksburg X 2 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Foreman		4. DATE OF DEATH Month August Day 17 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/57
9. AGE (In years last birthday) yrs. 12		IF UNDER 1 YEAR Months 12 Days 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Clifton LeRoy Lyles		14. MOTHER'S MAIDEN NAME Josephine Elizabeth Foreman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) ATELECTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATURITY DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/17 , 19 57 , to 8/18 , 19 57 , that I last saw the deceased alive on 8/17 , 19 57 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Maryland DATE SIGNED 8/18/57			
ACTUAL SIGNATURE G. F. Meadors		M.D. Damascus, Maryland	
PHYSICIAN'S NAME (Type) Dr. G. F. Meadors		M.D. Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19, 1957	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Purdim, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Molsworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE 8-19-57		24b. REGISTRAR'S SIGNATURE Evelyn B. Lawler	

207324XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08651

Reg. Dist. No.

223

08699

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>8 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanct & Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Hilma</i> Middle <i>Victoria</i> Last <i>Friberg</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>26</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 26 - 1882</i>	
9. AGE (In years last birthday) <i>74</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		11. BIRTHPLACE (State or foreign country) <i>Sweden</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Johan Johansson</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hospital Records</i>		Address <i>2 W. Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>451X</i> DUE TO <i>Hemorrhage in retroperitoneal tissue</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Rupture of arteriosclerotic aneurysm of abdominal aorta</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Heart stones, arteriosclerosis, coronary artery disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-15-57</i> , 19 <i>57</i> , to <i>8-26-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>8-25-57</i> , 19 <i>57</i> , and that death occurred at <i>6 PM</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Kenneth F. Laughlin</i> M.D.				ADDRESS (Street, city or town, state) <i>934 Elsworth Rd</i> DATE SIGNED <i>8-26-57</i>			
PHYSICIAN'S NAME (Type) <i>Kenneth F. Laughlin</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>8/29/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner C. Humphrey</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>8/28/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>William Doda</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1912</i>		6. PLACE OF BIRTH <i>Baltimore, Md</i>	
7. DATE OF DEATH <i>Aug 28 1957</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. DISEASE OR INJURY <i>Myocardial Infarction</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>	
15. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		16. SIGNATURE OF FUNERAL HOME <i>John Doe</i>	
17. SIGNATURE OF CLERK <i>John Doe</i>		18. SIGNATURE OF JUDGE <i>John Doe</i>	
19. SIGNATURE OF NOTARY <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	

RECEIVED
AUG 29 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08664

CERTIFICATE OF DEATH

08652, 218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Elizabeth</u> Last <u>Falks</u>		4. DATE OF DEATH Month <u>Aug</u> - Day <u>16</u> - Year <u>1937</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan - 3 - 1874</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>16</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md</u>		12. CHILD OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Wesley Walker</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Catherine Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <u>no</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Lena Gertrude Falks</u>		Address <u>31 Walker Ave, Gaithersburg, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smility</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes, arterio-sclerosis, organic dementia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 - 23 - 1935</u> , to <u>Aug - 16 - 1937</u> , that I last saw the deceased alive on <u>Aug - 14 - 1937</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>7 - Brooke Ave, Gaithersburg, Md.</u>		DATE SIGNED	
ACTUAL SIGNATURE <u>Nathan C. Miller</u> M.D.			
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Aug 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blanche S. Cook</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Residence

Residence
Baltimore
31 Baker Ave

Residence
Baltimore
414

Age - 16 - 29
Date - 3-18-74
Sex - M

Age - 16 - 29
Date - 3-18-74
Sex - M

Occupation
Student
Baltimore
Baltimore
Baltimore

Occupation
Student
Baltimore
Baltimore
Baltimore

Signature, Name, Address, and Date

BUREAU V. 2

AUG 19 1957

RECEIVED

Signature
Date - 14 - 27
Name - F. Miller
Name - C. Miller

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08654

08665

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 1 week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster 75-X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6751 Fairfax Road Apt. #2		d. STREET ADDRESS 329 East Clay Street	
3. NAME OF DECEASED (Type or print) JACOB ALLEN GEIST		4. DATE OF DEATH Month August Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1906
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager for Cigar Company		10b. KIND OF BUSINESS OR INDUSTRY New Holland, Penna.	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jacob G. Geist		14. MOTHER'S MAIDEN NAME Elizabeth Fry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Wife Laura Geist		Address 329 E. Clay St. Lancaster, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED Aug. 24, 1957	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Dremation	22b. DATE THEREOF 8-24-57	22c. NAME OF CEMETERY OR CREMATORY Dedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Prince George Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR Bessie M. Thompson	
ADDRESS Bethesda, Md.		DATE 8-26-57	

BUREAU V. 3

AUG 28 1957

RECEIVED

08666

CERTIFICATE OF DEATH

Reg. Dist. No.

08656 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 23 hr. 17 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Gibson				4. DATE OF DEATH Month August Day 6 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 6, 1957	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. Hours 23 Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Ralph Eugene Gibson				14. MOTHER'S MAIDEN NAME Margaret Ann Bryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Not				16. SOCIAL SECURITY NO.			
17. INFORMANT Ralph Eugene Gibson				Address Rt. #2 Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema & petechiae 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) bilateral fetal atelectasis DUE TO (c) Prematurity (33 wk) INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from on , 19 57 , to Aug 6 , 19 57 , that I last saw the deceased alive on Aug 6 , 19 57 , and that death occurred at 11:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring Md DATE SIGNED 8/7/57 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) [Signature]							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/8/57		22c. NAME OF CEMETERY OR CREMATORY East Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Calverton Maryland Md	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				24a. REC'D BY REGISTRAR [Signature]		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073223XV2

RECEIVED

MAY 13 1957

BUREAU V. 1

MAYLAND STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL RECORDS		MAYLAND STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL RECORDS	
CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES EARL RAY		1. NAME OF DECEASED JAMES EARL RAY	
2. SEX Male		2. SEX Male	
3. AGE 35		3. AGE 35	
4. DATE OF BIRTH Jan 5, 1922		4. DATE OF BIRTH Jan 5, 1922	
5. PLACE OF BIRTH Jackson, Mississippi		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Minister		6. OCCUPATION Minister	
7. CAUSE OF DEATH Suicide		7. CAUSE OF DEATH Suicide	
8. MANNER OF DEATH Natural		8. MANNER OF DEATH Natural	
9. PLACE OF DEATH Memphis, Tennessee		9. PLACE OF DEATH Memphis, Tennessee	
10. DATE OF DEATH April 4, 1968		10. DATE OF DEATH April 4, 1968	
11. SIGNATURE OF DECEASED James Earl Ray		11. SIGNATURE OF DECEASED James Earl Ray	
12. SIGNATURE OF WITNESS James Earl Ray		12. SIGNATURE OF WITNESS James Earl Ray	
13. SIGNATURE OF PHYSICIAN James Earl Ray		13. SIGNATURE OF PHYSICIAN James Earl Ray	
14. SIGNATURE OF CORONER James Earl Ray		14. SIGNATURE OF CORONER James Earl Ray	
15. SIGNATURE OF JURY James Earl Ray		15. SIGNATURE OF JURY James Earl Ray	
16. SIGNATURE OF JUDGE James Earl Ray		16. SIGNATURE OF JUDGE James Earl Ray	
17. SIGNATURE OF CLERK James Earl Ray		17. SIGNATURE OF CLERK James Earl Ray	
18. SIGNATURE OF REGISTRAR James Earl Ray		18. SIGNATURE OF REGISTRAR James Earl Ray	
19. SIGNATURE OF VICE REGISTRAR James Earl Ray		19. SIGNATURE OF VICE REGISTRAR James Earl Ray	
20. SIGNATURE OF ASSISTANT REGISTRAR James Earl Ray		20. SIGNATURE OF ASSISTANT REGISTRAR James Earl Ray	

08667

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Chevy Chase, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4114 Rosemary Street				d. STREET ADDRESS 4114 Rosemary Street			
3. NAME OF DECEASED (Type or print) First Margaret Middle H Last Gibson				4. DATE OF DEATH Month August Day 24 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1913		9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months 0 Days 16 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Magnus Halvansen			14. MOTHER'S MAIDEN NAME Martha Klinkenberg				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Chevy Chase, Md. Dr. Gilbert Rude-7700 Glendale Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) 7700 Glendale Dr. Frank Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 8/24/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
22d. LOCATION (City, town, or county) (State) Suitland, Maryland				22e. MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 8-26-57	
24b. REGISTRAR'S SIGNATURE Bennie M. Thompson				DATE August 24, 1957			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08668

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 FilmG219 8-12-57 et

08658

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 56 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 213 Whitmoor Terrace		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 213 Whitmoor Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marguerite Gilbert		4. DATE OF DEATH Month Day Year Aug. 7, 1957 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ken.	
11. BIRTHPLACE (State or foreign country) Ken.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Hampson		14. MOTHER'S MAIDEN NAME "Not Available"	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mary F. Gilbert (daughter)		Address Same # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Wilmington National Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hatter		24a. REC'D BY REGISTRAR AUG 8 1957	
ADDRESS 254 Cornell St. NW W.C.		24b. REGISTRAR'S SIGNATURE Frances Hatter	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **08659 723**

08610

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. + Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
				d. STREET ADDRESS 18621 Piney Branch			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eduthe Middle Gladys Last Gilrein				4. DATE OF DEATH Month August Day 19 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53		IF UNDER 24 HRS. Months 53 Days 53 Hours 53 Min. 53			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) New Hampshire	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Henry Mundy				14. MOTHER'S MAIDEN NAME Sarah Ann Hardy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. —			
17. INFORMANT Hospital Records				Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive metastasis Squamous 171X DUE TO cell carcinoma of cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) terminal cachexia DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month — Day — Year — Hour — a. m. — p. m. —				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 6 1944 19 — to August 19 1957 , that I last saw the deceased alive on 8-19-57 19 — and that death occurred at 1054 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Kenneth Laughlin M.D.				ADDRESS (Street, city or town, state) 934 Elmworth Dr. 8-19-57			
DATE SIGNED 8-19-57							
PHYSICIAN'S NAME (Type) KENNETH LAUGHLIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/57		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Worcester, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers ADDRESS Edwington Tr DC				24a. REC'D BY REGISTRAR — 24b. REGISTRAR'S SIGNATURE W W Chambers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		PREVIOUS ILLNESS	
CAUSE OF DEATH		IMMEDIATE CAUSE	
FUNDAMENTAL CAUSE		MORBID CAUSE	
SIGNATURE OF PHYSICIAN		DATE	
SIGNATURE OF REGISTRAR		DATE	
SIGNATURE OF WITNESS		DATE	
SIGNATURE OF CORONER		DATE	
SIGNATURE OF JURY		DATE	
SIGNATURE OF JUDGE		DATE	
SIGNATURE OF CLERK		DATE	
SIGNATURE OF SHERIFF		DATE	
SIGNATURE OF DEPUTY SHERIFF		DATE	
SIGNATURE OF CONSTABLE		DATE	
SIGNATURE OF JURY		DATE	
SIGNATURE OF JUDGE		DATE	
SIGNATURE OF CLERK		DATE	
SIGNATURE OF SHERIFF		DATE	
SIGNATURE OF DEPUTY SHERIFF		DATE	
SIGNATURE OF CONSTABLE		DATE	

BUREAU V. 3

AUG 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG219 8-29-57 et

08669

CERTIFICATE OF DEATH

08660

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown x1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>R.F.D. 1</u>			
3. NAME OF DECEASED (Type or print) <u>Florence Elizabeth Holliday</u> First Middle Last				4. DATE OF DEATH <u>August 21, 1957</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 19, 1957</u>	9. AGE (In years last birthday) <u>52 1/2 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Clarence Earl Holliday</u>				14. MOTHER'S MAIDEN NAME <u>Betty Elizabeth Saunders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Father</u>		Address <u>Germantown, Md. R.F.D. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ANOXIA</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>52 1/2 hrs</u> <u>52 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 19, 1957</u> , to <u>August 21, 1957</u> , that I last saw the deceased alive on <u>August 20, 1957</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert O. Warthen</u>		M.D. <u>3716 HOWARD AVE.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>8-21-57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT O. WARTHEN</u>		ADDRESS <u>KENSINGTON, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg</u> <u>1466</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Constance E. Fortner</u>		ADDRESS <u>Gaithersburg</u>		24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1957

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]		7. COUNTY OF BIRTH [Faint text]		8. MARITAL STATUS [Faint text]		9. OCCUPATION [Faint text]		10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF DECEASED [Faint text]		13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF PHYSICIAN [Faint text]		15. SIGNATURE OF CORONER [Faint text]		16. SIGNATURE OF JUDGE [Faint text]		17. SIGNATURE OF CLERK [Faint text]		18. SIGNATURE OF REGISTRAR [Faint text]		19. SIGNATURE OF [Faint text]		20. SIGNATURE OF [Faint text]		21. SIGNATURE OF [Faint text]		22. SIGNATURE OF [Faint text]		23. SIGNATURE OF [Faint text]		24. SIGNATURE OF [Faint text]		25. SIGNATURE OF [Faint text]		26. SIGNATURE OF [Faint text]		27. SIGNATURE OF [Faint text]		28. SIGNATURE OF [Faint text]		29. SIGNATURE OF [Faint text]		30. SIGNATURE OF [Faint text]		31. SIGNATURE OF [Faint text]		32. SIGNATURE OF [Faint text]		33. SIGNATURE OF [Faint text]		34. SIGNATURE OF [Faint text]		35. SIGNATURE OF [Faint text]		36. SIGNATURE OF [Faint text]		37. SIGNATURE OF [Faint text]		38. SIGNATURE OF [Faint text]		39. SIGNATURE OF [Faint text]		40. SIGNATURE OF [Faint text]		41. SIGNATURE OF [Faint text]		42. SIGNATURE OF [Faint text]		43. SIGNATURE OF [Faint text]		44. SIGNATURE OF [Faint text]		45. SIGNATURE OF [Faint text]		46. SIGNATURE OF [Faint text]		47. SIGNATURE OF [Faint text]		48. SIGNATURE OF [Faint text]		49. SIGNATURE OF [Faint text]		50. SIGNATURE OF [Faint text]		51. SIGNATURE OF [Faint text]		52. SIGNATURE OF [Faint text]		53. SIGNATURE OF [Faint text]		54. SIGNATURE OF [Faint text]		55. SIGNATURE OF [Faint text]		56. SIGNATURE OF [Faint text]		57. SIGNATURE OF [Faint text]		58. SIGNATURE OF [Faint text]		59. SIGNATURE OF [Faint text]		60. SIGNATURE OF [Faint text]		61. SIGNATURE OF [Faint text]		62. SIGNATURE OF [Faint text]		63. SIGNATURE OF [Faint text]		64. SIGNATURE OF [Faint text]		65. SIGNATURE OF [Faint text]		66. SIGNATURE OF [Faint text]		67. SIGNATURE OF [Faint text]		68. SIGNATURE OF [Faint text]		69. SIGNATURE OF [Faint text]		70. SIGNATURE OF [Faint text]		71. SIGNATURE OF [Faint text]		72. SIGNATURE OF [Faint text]		73. SIGNATURE OF [Faint text]		74. SIGNATURE OF [Faint text]		75. SIGNATURE OF [Faint text]		76. SIGNATURE OF [Faint text]		77. SIGNATURE OF [Faint text]		78. SIGNATURE OF [Faint text]		79. SIGNATURE OF [Faint text]		80. SIGNATURE OF [Faint text]		81. SIGNATURE OF [Faint text]		82. SIGNATURE OF [Faint text]		83. SIGNATURE OF [Faint text]		84. SIGNATURE OF [Faint text]		85. SIGNATURE OF [Faint text]		86. SIGNATURE OF [Faint text]		87. SIGNATURE OF [Faint text]		88. SIGNATURE OF [Faint text]		89. SIGNATURE OF [Faint text]		90. SIGNATURE OF [Faint text]		91. SIGNATURE OF [Faint text]		92. SIGNATURE OF [Faint text]		93. SIGNATURE OF [Faint text]		94. SIGNATURE OF [Faint text]		95. SIGNATURE OF [Faint text]		96. SIGNATURE OF [Faint text]		97. SIGNATURE OF [Faint text]		98. SIGNATURE OF [Faint text]		99. SIGNATURE OF [Faint text]		100. SIGNATURE OF [Faint text]	
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BUREAU V. 2

AUG 27 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> x0	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>8622 Melwood Dr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Agnes Mary Goubleman</u>		4. DATE OF DEATH Month Day Year <u>8 7 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-84</u> 85
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion-Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St. Paul Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Smythney</u>		14. MOTHER'S MAIDEN NAME <u>Matoush</u> (First name MARY)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>506-38-3495</u>	
17. INFORMANT <u>Dale E. Goubleman-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple metastases, Malignant Melanoma</u> <u>190x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/10</u> , 19 <u>57</u> , to <u>8/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/7</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8/7/57</u>			
ACTUAL SIGNATURE <u>Seymour Greenbaum</u> M.D.		PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 9, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>8-10-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08611 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08662

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 Albany Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NATHAN FRANCIS GRADY		4. DATE OF DEATH August 7 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1881
9. AGE (in years last birthday) 76 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (retired)		10b. KIND OF BUSINESS OR INDUSTRY Used Auto Tires	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Grady		14. MOTHER'S MAIDEN NAME Elizabeth Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Myrtle Willie Grady		Address Takoma Park, Md., 525 Albany Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Found dead in bed
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 7, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/9/57	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR 7/9/57
		24b. REGISTRAR'S SIGNATURE J. M. ...	

RECEIVED

AUG 12 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

611

STATE
DEPARTMENT

08671

CERTIFICATE OF DEATH

08663 216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>18401 DIXON AVENUE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIDA M GRIFFIN</u>		4. DATE OF DEATH Month Day Year <u>August 26 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Nevada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Billy Ohnigama</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>EVELYN DUDLEY</u>	
17. INFORMANT Address <u>8401 Dixon Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS, GENERALIZED</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CA INTRA-ABDOMINAL</u> DUE TO (c) <u>TO STATE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>UNABLE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIO SCLEROSIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>NONE</u> 19 <u>57</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 1957</u> to <u>AUGUST 25 1957</u> , that I last saw the deceased alive on <u>AUGUST 25 1957</u> and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>11502 Grandview Ave. Wheaton Md.</u>		DATE SIGNED <u>8/26/57</u>	
ACTUAL SIGNATURE <u>Belden R. Reap</u>			
PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>8/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Westboro, Mass.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 Madison St. N.W. Washington, D.C.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6871

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>Jan 1, 1900</i>
RESIDENCE <i>123 Main St, Baltimore, Md</i>		DATE OF DEATH <i>Aug 20, 1957</i>
CAUSE OF DEATH <i>Heart Disease</i>		PLACE OF DEATH <i>Home</i>
MANNER OF DEATH <i>Natural</i>		SEX <i>Male</i>
OCCUPATION <i>Teacher</i>		EDUCATION <i>High School</i>
RELIGION <i>Methodist</i>		DATE OF MARRIAGE <i>May 15, 1925</i>
NAME OF SPouse <i>Jane Doe</i>		DATE OF BIRTH OF SPouse <i>Mar 10, 1905</i>
NAME OF CHILDREN <i>John Jr., Mary, Robert</i>		DATE OF BIRTH OF CHILDREN <i>1928, 1930, 1935</i>
NAME OF PHYSICIAN <i>Dr. J. Smith</i>		DATE OF CONSULTATION <i>Aug 15, 1957</i>
NAME OF HOSPITAL <i>St. Mary's Hospital</i>		DATE OF ADMISSION <i>Aug 18, 1957</i>
NAME OF NURSE <i>Miss Brown</i>		DATE OF DEATH <i>Aug 20, 1957</i>
NAME OF CORONER <i>Mr. White</i>		DATE OF EXAMINATION <i>Aug 21, 1957</i>
NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		DATE OF BURIAL <i>Aug 22, 1957</i>

RECEIVED
AUG 27 1957
BUREAU V. B.

08672

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1724 North Troy Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Edmond Last Hanna				4. DATE OF DEATH Month August Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 21, 1888	
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) New York	
12. FATHER'S NAME John Hanna				14. MOTHER'S MAIDEN NAME Annie McQuide			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 048-01-6008		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X DUE TO Removal of innumerate artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of larynx DUE TO 5 minutes (c) 5 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 8, 1957 to August 8, 1957 , that I last saw the deceased alive on August 8, 1957 , and that death occurred at 8:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/8/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE John F. Potter M.D.							
PHYSICIAN'S NAME (Type) John F. Potter, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Sons ADDRESS 1756 Pa. Ave. NW				24a. REC'D BY REGISTRAR DATE 8-13-57		24b. REGISTRAR'S SIGNATURE Bessie M. Harrison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

RECEIVED

AUG 14 1957

08673

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 ROCKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 1304 Viers Mill Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Beverly Ann Middle Harding Last Harding				4. DATE OF DEATH Month AUGUST Day 6 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 6, 1957	
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 15 Min. 34		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant---		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Russell Nicholas Harding				14. MOTHER'S MAIDEN NAME Beverly Katherine Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Father		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Fetal Atlectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immaturity DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 15 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG 57 to AUG 57 , that I last saw the deceased alive on AUG 57 , and that death occurred at 5:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 6 AUG 57							
ACTUAL SIGNATURE Ira W. Pearlman M.D.							
PHYSICIAN'S NAME (Type) Ira W. Pearlman, M.D. 4700 Bradley Blvd. Chevy Chase, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/1957		22c. NAME OF CEMETERY OR CREMATORY Darnestown Presby Ch.		22d. LOCATION (City, town, or county) (State) Montg. Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24. REC'D BY REGISTRAR DATE 8-10-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2374275 XVO

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. S.

AUG 12 1957

RECEIVED

Robert J. Murphy - 1557 W. ...
Baltimore, Md.
1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08674

CERTIFICATE OF DEATH

08666

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>26 Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>1324 Vee Mill Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Bryan Eugene</i> Middle <i>Harding</i> Last <i>Harding</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>7</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 6, 1906</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>	
11. BIRTH PLACE (State or foreign country) <i>Md. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Russell Nicholas Harding</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Katharine Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Father</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fetal Stelectasis</i> 762.5 DUE TO <i>Immaturity</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Multiple Birth</i> DUE TO (c) <i>Multiple Birth</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>AUG 7, 1957</i> to <i>AUG 7, 1957</i> , that I last saw the deceased alive on <i>AUG 7, 1957</i> , and that death occurred at <i>7:50 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4700 Bradley Blvd, Chevy Chase, Md.</i> DATE SIGNED <i>7/10/57</i>			
ACTUAL SIGNATURE <i>Ira W. Pearlman</i> M.D.		PHYSICIAN'S NAME (Type) <i>Ira W. Pearlman, M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/9/1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Darnestown Presby Ch.</i>		22d. LOCATION (City, town, or county) (State) <i>Montg. Co. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</i>		24. REC'D BY REGISTRAR <i>8-10-57</i>	
24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. MEDICAL HISTORY [Illegible]	
10. SIGNATURE OF PHYSICIAN [Illegible]		11. SIGNATURE OF DEATH REGISTRAR [Illegible]		12. SIGNATURE OF WITNESSES [Illegible]	

BUREAU V. S.

AUG 12 1957

RECEIVED

13. NAME OF PHYSICIAN [Illegible]	14. ADDRESS OF PHYSICIAN [Illegible]
15. NAME OF DEATH REGISTRAR [Illegible]	16. ADDRESS OF DEATH REGISTRAR [Illegible]
17. NAME OF WITNESSES [Illegible]	18. ADDRESS OF WITNESSES [Illegible]

08612

CERTIFICATE OF DEATH

08667

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Conv. Home.</u>				d. STREET ADDRESS <u>1001 Kentland Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Bell Harrington</u>				4. DATE OF DEATH Month Day Year <u>August 17 1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1867</u>	
9. AGE (In years last birthday) yrs. <u>89</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired. HOUSEWIFE</u>				11. BIRTHPLACE (State or foreign country) <u>LISBON, MAINE</u>			
13. FATHER'S NAME <u>JOHN HOOKKIN</u>				14. MOTHER'S MAIDEN NAME <u>ARABEL BUCKMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. EDNA H. NUGENT, 1001 KENTLAND AVE., TAKOMA PARK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>40 years.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 2, 1957</u> , to <u>August 17, 1957</u> , that I last saw the deceased alive on <u>August 17, 1957</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>1746 K S.W. Wash. D.C.</u>				DATE SIGNED <u>8/17/57</u>			
ACTUAL SIGNATURE <u>Charles W. Humphreys, Jr.</u>				PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PORTLAND, MAINE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Humphreys, Jr.</u>				ADDRESS <u>Tak. Pk. D.C. 254 CARROLL ST. NW.</u>		24a. REC'D BY REGISTRAR <u>Edna Dodd</u>	
24b. REGISTRAR'S SIGNATURE <u>Edna Dodd</u>				DATE <u>7/20/57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08668

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Fla.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bozys</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gainesville</u> <u>48X-3</u>		d. STREET ADDRESS <u>R-4 Box 359</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>md R-117</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank E Hastings</u>		4. DATE OF DEATH <u>Aug 14 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-52</u>
9. AGE (in years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Fla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Hastings</u>		14. MOTHER'S MAIDEN NAME <u>Janet Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Peter Hastings</u>		Address <u>Stun #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>9298</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>drowning</u> (c) <u>due to</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Wounded by alone and fell in pond</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-14 1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) <u>Bozys Montg. md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-14-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>William B. Hilton, Barnesville, Md</u>		22d. LOCATION (City, town, or county) <u>Habeland Florida</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville, Md</u>		24a. REC'D BY REGISTRAR <u>Aug 16, 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>			

RECEIVED

AUG 20 1937

BUREAU V. S.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

STATE DEPARTMENT OF HEALTH - ATTORNEY IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 220 9-17-57

CERTIFICATE OF DEATH

08669

08676

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 11 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 902 LANGLEY DRIVE				d. STREET ADDRESS 1 902 LANGLEY DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last HEIGHAM				4. DATE OF DEATH Month AUGUST Day 2 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1869 NOV. 25, 1869		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM J. HEIGHAM				14. MOTHER'S MAIDEN NAME ANNE HIRST			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Miss Una Heigham, 902 Langley Dr. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , to Aug. 2, 1957 , that I last saw the deceased alive on Aug. 2, 1957 , and that death occurred at 2:20 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE John N. Andrews M.D.				ADDRESS (Street, city or town, state) 969 Colverville Rd. Silver Spring Md.			
DATE SIGNED Aug 2-57							
PHYSICIAN'S NAME (Type) JOHN N. ANDREWS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/5/57		22c. NAME OF CEMETERY OR CREMATORY ST. BARNABAS EPISCOPAL CHURCH		22d. LOCATION (City, town, or county) (State) OXEN HILL, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 8/8/57	
				24b. REGISTRAR'S SIGNATURE Frances Tolber			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 12 1957
BUREAU V. S.

BUREAU V. S.

AUG 12 1957

08677

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5518 Southwick Street				d. STREET ADDRESS 5518 Southwick Street			
3. NAME OF DECEASED (Type or print) First Matilda Middle M. Last HENKELMAN				4. DATE OF DEATH Month August Day 14 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 29		IF UNDER 24 HRS. Hours 29 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME George H. Henkelman				14. MOTHER'S MAIDEN NAME Anna Elizabeth Stein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Augusta Henkelman-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting aneurysm of the Aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis of the Aorta DUE TO (c) many years				INTERVAL BETWEEN ONSET AND DEATH many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville, Maryland				20g. (County) Rockville, Maryland			
20h. (State) Rockville, Maryland							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Paula E. Mahler, M.D. M.D.							
PHYSICIAN'S NAME (Type) Paula Mahler, M.D.				5311 Roosevelt Street, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 8-14-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

NAME OF DECEASED George E. Beckman		SEX Male	
DATE OF BIRTH August 14, 1907		PLACE OF BIRTH St. Louis, Missouri	
DATE OF DEATH August 14, 1957		PLACE OF DEATH St. Louis, Missouri	
TIME OF DEATH 10:30 PM		CAUSE OF DEATH Heart Disease	
PLACE OF DEATH St. Louis, Missouri		MANNER OF DEATH Natural	
NAME OF DECEASED George E. Beckman		SEX Male	
DATE OF BIRTH August 14, 1907		PLACE OF BIRTH St. Louis, Missouri	
DATE OF DEATH August 14, 1957		PLACE OF DEATH St. Louis, Missouri	
TIME OF DEATH 10:30 PM		CAUSE OF DEATH Heart Disease	
PLACE OF DEATH St. Louis, Missouri		MANNER OF DEATH Natural	

BUREAU V. 3

AUG 19 1957

RECEIVED

08678

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md. c. LENGTH OF STAY IN 1b 1 wk. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Pennsylvania c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clairton, Pa. (Rural) R.D. #1 Coal Valley d. STREET ADDRESS R.D. #1, Coal Valley Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Heron Last Aug. 4. DATE OF DEATH Month Aug. Day 18 Year 19 57		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 15, 1902 9. AGE (In years last birthday) 55 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Willouk, Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Holmes 14. MOTHER'S MAIDEN NAME Sarah A. Fornear, Holmes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Jean Wise, Daughter Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiac-vascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 26 hrs. 10 yrs.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 8-17-57 , 19____, to 8-18 , 19 57 , that I last saw the deceased alive on 8-18-57 , 19____, and that death occurred at 1:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8805 Conn Ave. DATE SIGNED 8/18/57 ACTUAL SIGNATURE John B. Umhau M.D. Chouy Chase PHYSICIAN'S NAME (Type) John B. Umhau	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 8-19-57 22b. DATE THEREOF 8-19-57 22c. NAME OF CEMETERY OR CREMATORY Jefferson Meth. Cem. 22d. LOCATION (City, town, or county) (State) R.D. #1, Clairton, Pa.		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md. 24a. REC'D BY REGISTRAR DATE 8-22-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08679

CERTIFICATE OF DEATH

08672

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN lb 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,004 Colesville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLIFTON Middle DAVID Last HOWELLS				4. DATE OF DEATH Month AUGUST Day 9 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/91	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ordnance worker				10b. KIND OF BUSINESS OR INDUSTRY Fidelity Storage Co.		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Arthur Howells				14. MOTHER'S MAIDEN NAME Anne Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 577-09-3491		17. INFORMANT Mr. F. W. Davis, 12,004 Colesville Road Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized inanition 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis generalized DUE TO (c) Carcinoma of colon INTERVAL BETWEEN ONSET AND DEATH 7 days 10 months 14 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 56 , to Aug , 19 57 , that I last saw the deceased alive on Aug 9 , 19 57 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8641 Colesville Road Silver Spring, Md. DATE SIGNED Aug 9, 57							
ACTUAL SIGNATURE Ralph F. Patten M.D.				PHYSICIAN'S NAME (Type) RALPH F. PATTEN M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/12/57		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) Prince Geo. County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 8/21/57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX M		3. AGE 45	
4. DATE OF DEATH AUG 15 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN J. J. JONES	
10. SIGNATURE OF REGISTRAR J. J. JONES		11. SIGNATURE OF WITNESS J. J. JONES		12. SIGNATURE OF DECEASED J. J. JONES	
13. SIGNATURE OF DECEASED J. J. JONES		14. SIGNATURE OF DECEASED J. J. JONES		15. SIGNATURE OF DECEASED J. J. JONES	
16. SIGNATURE OF DECEASED J. J. JONES		17. SIGNATURE OF DECEASED J. J. JONES		18. SIGNATURE OF DECEASED J. J. JONES	
19. SIGNATURE OF DECEASED J. J. JONES		20. SIGNATURE OF DECEASED J. J. JONES		21. SIGNATURE OF DECEASED J. J. JONES	
22. SIGNATURE OF DECEASED J. J. JONES		23. SIGNATURE OF DECEASED J. J. JONES		24. SIGNATURE OF DECEASED J. J. JONES	
25. SIGNATURE OF DECEASED J. J. JONES		26. SIGNATURE OF DECEASED J. J. JONES		27. SIGNATURE OF DECEASED J. J. JONES	
28. SIGNATURE OF DECEASED J. J. JONES		29. SIGNATURE OF DECEASED J. J. JONES		30. SIGNATURE OF DECEASED J. J. JONES	
31. SIGNATURE OF DECEASED J. J. JONES		32. SIGNATURE OF DECEASED J. J. JONES		33. SIGNATURE OF DECEASED J. J. JONES	
34. SIGNATURE OF DECEASED J. J. JONES		35. SIGNATURE OF DECEASED J. J. JONES		36. SIGNATURE OF DECEASED J. J. JONES	
37. SIGNATURE OF DECEASED J. J. JONES		38. SIGNATURE OF DECEASED J. J. JONES		39. SIGNATURE OF DECEASED J. J. JONES	
40. SIGNATURE OF DECEASED J. J. JONES		41. SIGNATURE OF DECEASED J. J. JONES		42. SIGNATURE OF DECEASED J. J. JONES	
43. SIGNATURE OF DECEASED J. J. JONES		44. SIGNATURE OF DECEASED J. J. JONES		45. SIGNATURE OF DECEASED J. J. JONES	
46. SIGNATURE OF DECEASED J. J. JONES		47. SIGNATURE OF DECEASED J. J. JONES		48. SIGNATURE OF DECEASED J. J. JONES	
49. SIGNATURE OF DECEASED J. J. JONES		50. SIGNATURE OF DECEASED J. J. JONES		51. SIGNATURE OF DECEASED J. J. JONES	
52. SIGNATURE OF DECEASED J. J. JONES		53. SIGNATURE OF DECEASED J. J. JONES		54. SIGNATURE OF DECEASED J. J. JONES	
55. SIGNATURE OF DECEASED J. J. JONES		56. SIGNATURE OF DECEASED J. J. JONES		57. SIGNATURE OF DECEASED J. J. JONES	
58. SIGNATURE OF DECEASED J. J. JONES		59. SIGNATURE OF DECEASED J. J. JONES		60. SIGNATURE OF DECEASED J. J. JONES	
61. SIGNATURE OF DECEASED J. J. JONES		62. SIGNATURE OF DECEASED J. J. JONES		63. SIGNATURE OF DECEASED J. J. JONES	
64. SIGNATURE OF DECEASED J. J. JONES		65. SIGNATURE OF DECEASED J. J. JONES		66. SIGNATURE OF DECEASED J. J. JONES	
67. SIGNATURE OF DECEASED J. J. JONES		68. SIGNATURE OF DECEASED J. J. JONES		69. SIGNATURE OF DECEASED J. J. JONES	
70. SIGNATURE OF DECEASED J. J. JONES		71. SIGNATURE OF DECEASED J. J. JONES		72. SIGNATURE OF DECEASED J. J. JONES	
73. SIGNATURE OF DECEASED J. J. JONES		74. SIGNATURE OF DECEASED J. J. JONES		75. SIGNATURE OF DECEASED J. J. JONES	
76. SIGNATURE OF DECEASED J. J. JONES		77. SIGNATURE OF DECEASED J. J. JONES		78. SIGNATURE OF DECEASED J. J. JONES	
79. SIGNATURE OF DECEASED J. J. JONES		80. SIGNATURE OF DECEASED J. J. JONES		81. SIGNATURE OF DECEASED J. J. JONES	
82. SIGNATURE OF DECEASED J. J. JONES		83. SIGNATURE OF DECEASED J. J. JONES		84. SIGNATURE OF DECEASED J. J. JONES	
85. SIGNATURE OF DECEASED J. J. JONES		86. SIGNATURE OF DECEASED J. J. JONES		87. SIGNATURE OF DECEASED J. J. JONES	
88. SIGNATURE OF DECEASED J. J. JONES		89. SIGNATURE OF DECEASED J. J. JONES		90. SIGNATURE OF DECEASED J. J. JONES	
91. SIGNATURE OF DECEASED J. J. JONES		92. SIGNATURE OF DECEASED J. J. JONES		93. SIGNATURE OF DECEASED J. J. JONES	
94. SIGNATURE OF DECEASED J. J. JONES		95. SIGNATURE OF DECEASED J. J. JONES		96. SIGNATURE OF DECEASED J. J. JONES	
97. SIGNATURE OF DECEASED J. J. JONES		98. SIGNATURE OF DECEASED J. J. JONES		99. SIGNATURE OF DECEASED J. J. JONES	
100. SIGNATURE OF DECEASED J. J. JONES		101. SIGNATURE OF DECEASED J. J. JONES		102. SIGNATURE OF DECEASED J. J. JONES	

RECEIVED
AUG 22 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08680

CERTIFICATE OF DEATH

086734

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 11 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1221 DALE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle LACEY Last HUNTER		4. DATE OF DEATH Month AUG. Day 18 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/78
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. CLARKE		14. MOTHER'S MAIDEN NAME FRANCES T. TRUNNELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-36-1834	
17. INFORMANT Mrs. Louise H. Hughes		Address 13,500 Grenoble Dr. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Fibrosis 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 55 , to August 18 , 19 57 , that I last saw the deceased alive on August 16 , 19 57 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state). DATE SIGNED 237 Georgia Ave, Silver Spring, Md Aug 19 57			
ACTUAL SIGNATURE Aaron H. Traum		M.D. 237 Georgia Ave, Silver Spring, Md Aug 19 57	
PHYSICIAN'S NAME (Type) Aaron H. Traum			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/21/57	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR 8/26/57		24b. REGISTRAR'S SIGNATURE Frances Potter	

BUREAU V. S.

AUG 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 215											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>					c. LENGTH OF STAY IN 1b <u>D.O.A.</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Maryland</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>Jennings</u> Last <u>HURST</u>					4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>19 57</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-24</u>		9. AGE (In years last birthday) <u>33</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR Months Days Hours Min.			
13. FATHER'S NAME <u>Samuel Daniel HURST</u>					14. MOTHER'S MAIDEN NAME <u>Vida (last name unknown)</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Currently</u>					16. SOCIAL SECURITY NO. <u>263 60 3052</u>		17. INFORMANT <u>Official Navy Records</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis left Ant. descending branch</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriolar nephrosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic passive congestion of all viscera; Pulmonary edema</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Tampa, Florida</u>		(County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>8-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tampa, Florida</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u>					ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>Mary E. Gandy</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Gandy</u>		

DATE SIGNED
23 Aug. 1957

M.D. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Broschart
EXAMINER'S NAME (Type) Frank J. Broschart, MD

STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08613

CERTIFICATE OF DEATH

Reg. Dist. No.

086753

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 5 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mattie Middle Ellen Last Hutt				4. DATE OF DEATH Month August Day 13 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-18-78	
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Stanley Taylor				14. MOTHER'S MAIDEN NAME Mary C. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.8 Congestive Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Reaction DUE TO (c) Carcinomatosis of Omentum & Colon				INTERVAL BETWEEN ONSET AND DEATH terminal six months 9 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1957 to 8-13-57 , that I last saw the deceased alive on 8-12-57 and that death occurred at 5:53 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Hare M.D.				ADDRESS (Street, city or town, state) Takoma Park, Md. DATE SIGNED 8/13/57			
PHYSICIAN'S NAME (Type) Robert A. HARE, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/57		22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Mt. Rainier, Inc.				ADDRESS Md.		24a. REC'D BY REGISTRAR Aug 19 1957	
				24b. REGISTRAR'S SIGNATURE J. Wilson Dadds			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 7 hrs 45 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California 18x22		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Naval Hosp., NNMC, Bethesda, Md.				d. STREET ADDRESS Long Apts		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Imholte Last Imholte				4. DATE OF DEATH Month August Day 11 Year 19 57			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 11, 1957	
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months 7 Days 45		IF UNDER 24 HRS. Hours 7 Min. 45			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Gerald J. Imholte				14. MOTHER'S MAIDEN NAME Luella Ione Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Gerald J. Imholte, Longs Apts, California, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (abnormal pulmonary ventilation) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prematurity DUE TO (c) 45 minutes							INTERVAL BETWEEN ONSET AND DEATH 7 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11 Aug 1957 to 11 Aug 1957 , that I last saw the deceased alive on 11 August 1957 , and that death occurred at 8:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Daniel Shuptar				M.D. U.S. Naval Hospital, NNMC, Beth. Md. 8-11-57			
PHYSICIAN'S NAME (Type) LT Daniel Shuptar, MC, USN				U.S. Naval Hospital, NNMC, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 13 Aug. 1957		22c. NAME OF CEMETERY OR CREMATORY St. Anne's Church Cemetery		22d. LOCATION (City, town, or county) (State) Kimball, Minnesota	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Campbell				ADDRESS 2557 Wisconsin Ave, Bethesda, MD		24a. REC'D BY REGISTRAR 8-11-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 3

AUG 13 1957

RECEIVED

08683

CERTIFICATE OF DEATH

08677

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 hr. 17 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.				d. STREET ADDRESS #10 Robin Road			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last JACKSON				4. DATE OF DEATH Month August Day 6 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5 1957		9. AGE (In years last birthday) yrs. 8	IF UNDER 1 YEAR Months 8 Days 17	IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Fussell JACKSON				14. MOTHER'S MAIDEN NAME Elois WILLS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hyaline Membrane Disease 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 August , 19 57 , to 6 August , 19 57 , that I last saw the deceased alive on 6 August 1957 , 19 57 , and that death occurred at 4:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 8-7-57							
ACTUAL SIGNATURE J. C. Parke, Jr.				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) J. C. PARKE, JR. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-7-57		22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		22d. LOCATION (City, town, or county) (State) Waldorf, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George E. Edman Huntt & Ryan, Waldorf, Maryland				24a. REC'D BY REGISTRAR DATE 8-7-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051211XV3

BUREAU V. S.

AUG 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08678

08684

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 47 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 6938 Blaisdell Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle Emma Last Jensen				4. DATE OF DEATH Month August Day 17 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1895	
9. AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Accounting		11. BIRTHPLACE (State or foreign country) Idaho	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wilford Phippen		14. MOTHER'S MAIDEN NAME Emma Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 556-12-0974		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKINS DISEASE 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 57 , to August 17 , 19 57 , that I last saw the deceased alive on August 17 , 19 57 , and that death occurred at 9:45 p. m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/18/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 8/20/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Whittier, LA Co. California	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 8-22-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased		Date of Death	
John William		July 10, 1957	
Age		45 years	
Sex		Male	
Race		White	
Marital Status		Married	
Place of Birth		Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Immediate Cause		Myocardial Infarction	
Underlying Cause		Coronary Atherosclerosis	
Contributing Cause		Hypertension	
Manner of Death		Natural	
Place of Death		Home	
Physician		Dr. J. H. Smith	
Medical Examiner		Dr. J. H. Smith	
Burial Place		St. John's Cemetery	
Burial Date		July 12, 1957	
Burial Time		10:00 AM	
Burial Place		St. John's Cemetery	
Burial Date		July 12, 1957	
Burial Time		10:00 AM	

RECEIVED
BUREAU V. S.
 AUG 26 1957

08614

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>West Cottage, Wash. San. Hosp.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ERNEST</u> First <u>(Wm)</u> Middle <u>Joerg</u> Last				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/29/175</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>	
13. FATHER'S NAME <u>Gottlieb Joerg</u>				14. MOTHER'S M maiden name <u>Mary Wassenfallen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give unit or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Medical records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion - recurrent, acute</u> Terminal (b) <u>Coronary Occlusion</u> three wks. (c) <u>Arteriosclerosis</u> years. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8-10-</u> , 19 <u>57</u> , to <u>8-30-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-30-</u> , 19 <u>57</u> , and that death occurred at <u>10:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>		DATE SIGNED <u>8/31/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. HARE.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>		22b. DATE THEREOF <u>9/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shelton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Indianapolis, Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St. N.W. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. McConde</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

RECEIVED
SEP 5 1957
BUREAU V. S.

08685

CERTIFICATE OF DEATH

08680

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAIRFAX</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALEXANDRIA</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>6908 CHACO ROAD</u>		
3. NAME OF DECEASED (Type or print) <u>TWIN "A" Baby Boy Johnson</u>		4. DATE OF DEATH <u>August 28 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 27/57</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR <u>1</u> Months <u>15</u> Days <u>18</u> Hours <u>18</u> Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>FRANK J. JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH GARDNER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		
17. INFORMANT <u>FRANK J. JOHNSON - SAME FATHER</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>769.0 Prematurity</u> DUE TO (b) <u>Maternal Toxemia (Ruptured Appendix)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>27 Aug</u> , 19 <u>57</u> , to <u>28 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>28 Aug</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave Bethesda Md.</u> DATE SIGNED <u>—</u>				
ACTUAL SIGNATURE <u>R H Mitchell</u> M.D. <u>—</u>				
PHYSICIAN'S NAME (Type) <u>R H MITCHELL</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>
22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u> ADDRESS <u>—</u>				
24a. REC'D BY REGISTRAR <u>DATE 9-4-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beasie M. Shomberg</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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RECEIVED

SEP 6 1957

BUREAU V. S.

9/2/87

Robert Hill Chemistry

Prince Georges - Maryland

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08686

CERTIFICATE OF DEATH

08681

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Virginia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>6908 Chaco Road</u>	
3. NAME OF DECEASED (Type or print) <u>Twin</u> First <u>Boy "B"</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27-57</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>27</u> Hours <u>3</u> Min. <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Jamison Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Frank J. Johnson - Same Item #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Respiratory</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>4 hours</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 Aug</u> , 19 <u>57</u> , to <u>28 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>28 Aug</u> , 19 <u>57</u> , and that death occurred at <u>4:50</u> A.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>TH Mitchell</u> M.D.		<u>8215 Wisconsin Ave</u> <u>28 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>TH MITCHELL MD</u> <u>Bethesda Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9/3/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pamphrey</u> ADDRESS <u>7557 Wis. Avenue, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9-4-57</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

2174251XV2

Frank J. Johnson - 2110 1st Ave. S.

BUREAU V. S.

SEP 6 1957

RECEIVED

1957 W. L. Kneive, Bell-234a,

08615

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lithonia</u> 49X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>				e. STREET ADDRESS <u>P.O. Box 233</u>			
3. NAME OF DECEASED (Type or print) <u>Grace</u> First <u>Elizabeth</u> Middle <u>Johnson</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-21-96</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kansas.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Crawford</u>				14. MOTHER'S MAIDEN NAME <u>Hilda ERICSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Husband -</u> Address <u>Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>158X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Carcinoma primary Colon splenic flexure</u> (c) <u>Carcinoma primary Colon splenic flexure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 2</u> , 19 <u>57</u> , to <u>Aug 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 9</u> , 19 <u>57</u> , and that death occurred at <u>12:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D.				ADDRESS (Street, city or town, state) <u>9601 Colesville Rd</u> DATE SIGNED <u>8-10-57</u>			
PHYSICIAN'S NAME (Type) <u>John N Andrews M.D.</u>				<u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Ladd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOYD

STANDARD

1957 1 3 07

1. The first part of the document is a title page. It contains the title "The first part of the document is a title page." and the author "The first part of the document is a title page."

10/15/79

BUREAU V. S.

AUG 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08683

08687

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood Pk. - Silver Spr.</u> X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>610 Hollywood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mae</u> First		Middle <u>Johnson</u> Last		4. DATE OF DEATH <u>Aug.</u> Month		Day <u>14</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28-1874</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Mont. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Jackson Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Harding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-34-7405</u>		17. INFORMANT Address <u>Daughters & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis, Coronary Artery Disease</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension and renal disease</u> DUE TO <u>1172</u> (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>August 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 12</u> , 19 <u>57</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Silver Spring, Md.</u> DATE SIGNED <u>8/14/57</u>							
ACTUAL SIGNATURE <u>A. D. Bonifant</u>				M.D. <u>Sandy Sping, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8-17-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>			

08688

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Missouri b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 95 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 114 North Chelsea Avenue			
3. NAME OF DECEASED (Type or print) First Margaret Middle Ruth Last Kapprel				4. DATE OF DEATH Month August Day 13 , Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1918	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Rainey				14. MOTHER'S MAIDEN NAME Nancy Mann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure - Hepatitis of unknown etiology 173x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chorio carcinoma DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 days 8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 10, 1957 , to August 13, 1957 , that I last saw the deceased alive on August 13, 1957 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. Nadler M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/13/57			
PHYSICIAN'S NAME (Type) Charles F. Nadler, M. D.				ADDRESS National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 8/13/57	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Kansas City, Missouri			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 8-14-57	24b. REGISTRAR'S SIGNATURE Bea M. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 CERTIFICATE OF DEATH

NAME OF DECEASED John Henry		SEX Male		RACE White		DATE OF BIRTH June 8, 1918		PLACE OF BIRTH Maryland	
RESIDENCE 121 North Chester Avenue		OCCUPATION Unemployed		CAUSE OF DEATH Unknown		MANNER OF DEATH Natural		MEDICAL ATTENDANT The Clinical Center, Baltimore, Md.	
DATE OF DEATH August 13, 1957		TIME OF DEATH 11:00 AM		PLACE OF DEATH Home		SIGNATURE OF DECEASED (None)		SIGNATURE OF MEDICAL ATTENDANT (None)	
SIGNATURE OF DECEASED (None)		SIGNATURE OF MEDICAL ATTENDANT (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF DECEASED (None)	

RECEIVED
 AUG 19 1957
 BUREAU V. 5

08689

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle MAY Last KEENE				4. DATE OF DEATH Month AUGUST Day 7 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1895	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN GATES				14. MOTHER'S MAIDEN NAME NEALY GATES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT HERMAN C. KEENE CITY 13, NORBECK RD. ROCKVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive heart failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Uremia						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of cervix							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/2 , 19 57 , to 8/7 , 19 57 , that I last saw the deceased alive on 8/6 , 19 57 , and that death occurred at 12:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 615 W. Montgomery Ave, Rockville, Md. DATE SIGNED 8/7/57							
ACTUAL SIGNATURE Stephen C. Cromwell				PHYSICIAN'S NAME (Type) STEPHEN C. CROMWELL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Smithland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 517-11th St. S.E.				24a. REC'D BY REGISTRAR AUG 12 1957		24b. REGISTRAR'S SIGNATURE Beatrix Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

BUREAU Y. 1

AUG 12 1957

RECEIVED

08690

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08686

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4807 Randolph Road, Silver Spring				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Newton Middle Amos Last Kendall				4. DATE OF DEATH Month August Day 24 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1883		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 8 Days 2	IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? Us	
13. FATHER'S NAME Amos Fenton Kendall				14. MOTHER'S MAIDEN NAME Martha Gordon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Pauline Ertter, same as Item #2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) _____ Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8/24/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/1957		22c. NAME OF CEMETERY OR CREMATORY Chestnut Grove		22d. LOCATION (City, town, or county) (State) Fairfax Co. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR 9-4-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [Illegible]
 SEX: [Illegible] AGE: [Illegible]
 DATE OF BIRTH: [Illegible]
 PLACE OF BIRTH: [Illegible]
 OCCUPATION: [Illegible]
 CAUSE OF DEATH: [Illegible]
 MANNER OF DEATH: [Illegible]
 SIGNATURE OF EXAMINER: [Illegible]
 DATE: [Illegible]

RECEIVED
 SEP 6 1957
 BUREAU V. 2

Robert A. [Illegible]
 1557 W. [Illegible]
 [Illegible]

08691

CERTIFICATE OF DEATH

08688

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY M				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4618 Chestnut Street				d. STREET ADDRESS 4618 Chestnut Street x2			
3. NAME OF DECEASED (Type or print) First Olivia Middle KNIGHT Last KNIGHT				4. DATE OF DEATH Month August Day 3 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1888	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 0 Days 16	IF UNDER 24 HRS. Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Govt. Employee		10b. KIND OF BUSINESS OR INDUSTRY Govt.		11. BIRTHPLACE (State or foreign country) Big Fork, Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Victor L. Knight				14. MOTHER'S MAIDEN NAME Amelia Knight Larsen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. M. L. Bixby-Same Item #2			Address Cousin
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from OCTOBER, 1950 , to Aug. 3 , 19 57 , that I last saw the deceased alive on Aug. 3 , 19 57 , and that death occurred at 11:43 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4709 Montg. Lane, Bethesda, Md. DATE SIGNED 8/3/57 ACTUAL SIGNATURE Paul D. Cantor M.D. PHYSICIAN'S NAME (Type) Paul D. Cantor, M.D. 4709 Montgomery Lane, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit	22b. DATE THEREOF 8/ 5 /1957	22c. NAME OF CEMETERY OR CREMATORY Schoolcraft Memorial	22d. LOCATION (City, town, or county) (State) Kalamazoo Co. Michigan				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.			24a. REC'D BY REGISTRAR DATE 8-7-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED Victor A. White		2. SEX Male		3. AGE 39 years		4. DATE OF DEATH July 17, 1957		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. OCCUPATION Engineer		8. BIRTH DATE July 17, 1918		9. BIRTH PLACE St. Louis, Mo.		10. MARRIAGE Married		11. EDUCATION High School		12. RELIGION Catholic	
13. PRESENT ADDRESS 410 Chestnut Street		14. HOME ADDRESS 410 Chestnut Street		15. TELEPHONE 410 Chestnut Street		16. PHYSICIAN Dr. J. H. Smith		17. HOSPITAL None		18. BURIAL PLACE St. Mary's Cemetery	
19. SIGNATURE OF DECEASED Victor A. White		20. SIGNATURE OF NEXT OF KIN Mrs. J. H. Smith		21. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		22. SIGNATURE OF REGISTRAR J. H. Smith		23. SIGNATURE OF CLERK J. H. Smith		24. SIGNATURE OF WITNESS J. H. Smith	

RECEIVED
AUG 9 1957
BUREAU V. 1

08616

CERTIFICATE OF DEATH

08689

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ednor</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Karen</u> Middle <u>Lee</u> Last <u>Kreiger</u>				4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-57</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>		IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Richard K. Kreiger</u>		14. MOTHER'S MAIDEN NAME <u>Eunice Beamesderger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>108-10-10000</u>		17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 days</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>8-4-57</u> to <u>8-9-57</u> , that I last saw the deceased alive on <u>8-6-57</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert D. Glick</u> M.D.				ADDRESS (Street, city or town, state) <u>Silver Spring, Maryland</u> DATE SIGNED <u>8-9-57</u>			
PHYSICIAN'S NAME (Type) <u>Herbert D. Glick, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington San & Hosp</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Hare, M. H.</u> ADDRESS <u>Wash. San. & Hosp.</u>				24a. REC'D BY REGISTRAR DATE <u>7/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Helm</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075332XVO

BUREAU V. M.

AUG 22 1957

RECEIVED

08692

CERTIFICATE OF DEATH

08690

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 55 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3				d. STREET ADDRESS 1324 29th Street, N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Cascaden Last KRINER		4. DATE OF DEATH Month August Day 12 Year 19 57		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 May 1894		9. AGE (In years last birthday) yrs. 63		10. IF UNDER 1 YEAR: Months 63 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Bryon KRINER (579 38 5059)			
14. MOTHER'S MAIDEN NAME Margaret Cascaden				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 7-06-11 to 3-1-45			
16. SOCIAL SECURITY NO. XXXXXX				17. INFORMANT (Wife) Mrs. Isabel W. Kriner (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobular bilateral DUE TO 471x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Fibrosis + emphysema, far advanced, chronic DUE TO (c) years INTERVAL BETWEEN ONSET AND DEATH 48 hrs						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 June , 19 57 , to 12 August , 19 57 , that I last saw the deceased alive on 12 August , 19 57 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-13-57							
ACTUAL SIGNATURE R. J. Mc Carthy				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph & Sons ADDRESS 1756 Penn. Ave., N.W. Wash. D.C.				24a. REC'D BY REGISTRAR DATE 8-12-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

15 AUG 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08693

CERTIFICATE OF DEATH

08691

Reg. Dist. No.

274

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 MANCHESTER PLACE				d. STREET ADDRESS 1 6 MANCHESTER PLACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle LANKFORD Last LANKFORD				4. DATE OF DEATH Month AUGUST Day 14 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/1/94		9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TYPIST		10b. KIND OF BUSINESS OR INDUSTRY Nat'l. Wildlife Fed.		11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SERVERT RUNNING				14. MOTHER'S MAIDEN NAME KAREN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 468-01-8569		17. INFORMANT Address Mr. Josh E. Lankford, 6 Manchester Place Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PHARYNX 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-16 , 19 57 , to 8-14 , 19 57 , that I last saw the deceased alive on 8-14 , 19 57 , and that death occurred at 10:15 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9013 FLOWER AVE SILVER SPRING, MD. DATE SIGNED 8/15/57 ACTUAL SIGNATURE L.B. Snow M.D. PHYSICIAN'S NAME (Type) L. B. SNOW							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8/17/57		22c. NAME OF CEMETERY OR CREMATORY Menomonie, Wisconsin		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Danner & Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 8/26/57		24b. REGISTRAR'S SIGNATURE Francis Feller	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1912</i></p>	
<p>5. Place of birth: <i>Baltimore, Md.</i></p>		<p>6. Date of death: <i>Aug 28, 1957</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	
<p>11. Date of registration: <i>Aug 28, 1957</i></p>		<p>12. Office of registration: <i>Baltimore, Md.</i></p>	

BUREAU V. R.

AUG 28 1957

RECEIVED

08694

CERTIFICATE OF DEATH

08694

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Celeste Last La Pointe				4. DATE OF DEATH Month August Day 30 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1957		9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 6 Days 8	IF UNDER 24 HRS. Hours 8 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Minor Child			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter G. La Pointe				14. MOTHER'S MAIDEN NAME Teresa Keating			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 7540 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease - Tetralogy of Fallot DUE TO (c) Absent Left PA - INTERVAL BETWEEN ONSET AND DEATH 3 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Surgery							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 18 , 19 57 , to August 30 , 19 57 , that I last saw the deceased alive on August 30 , 19 57 , and that death occurred at 5:10 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/31/57 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Theodore Cooper				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Theodore Cooper, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-31-57		22c. NAME OF CEMETERY OR CREMATORY Columbia Memorial Park		22d. LOCATION (City, town, or county) (State) Fairfax Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Eickenberry				24. RECEIVED BY REGISTRAR SEP 3 1957 REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 3 1957
BUREAU V. R.

08695

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1006 Monroe St., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Robert Last LATNEY				4. DATE OF DEATH Month August Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 July 1879		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Humphrey LATNEY				14. MOTHER'S MAIDEN NAME Margaret TAYLOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT (Daughter) Mrs. Dorothy L. PORTER (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7 Aug. , 19 57 , to 13 Aug. , 19 57 , that I last saw the deceased alive on 13 Aug. , 19 57 , and that death occurred at 9:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED August Miale, Jr. M.D. U.S. Naval Hospital, Bethesda, Md. 8-14-57							
ACTUAL SIGNATURE August Miale, Jr. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-16-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemtery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE MC GUIRE, 1820 9th St., N.W. Washington, D. C.				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Mary E. Farrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 15 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08693

Reg. Dist. No. 214

08696

1. PLACE OF DEATH Montgomery COUNTY				2. USUAL RESIDENCE (HOME) OF DECEASED District of Columbia STATE COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Kensington			LENGTH OF STAY (in this place) 9 Mo.		CITY (If outside corporate limits, write RURAL and give nearest town) 47x-3		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kensington Gardens San. Kensington, Maryland				STREET ADDRESS (If rural give location) 4000 Cathedral Ave., N.W.			
3. NAME OF DECEASED (Type or Print) Mary E. LEE				4. DATE OF DEATH (Month) (Day) (Year) Aug 25 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Div.	8. DATE OF BIRTH Feb 22, 1875		9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf			10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Phillip Grill				14. MOTHER'S MAIDEN NAME Catherine Brandt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS P. August Grill 5211 Sholbourne Rd.		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4341 IMMEDIATE CAUSE (A) Acute Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 3 Days	
ANTECEDENT CAUSE(S) DUE TO Rheumatoid Arthritis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Aug. 23, 19 57, to Aug. 25 19 57, that I last saw the deceased alive on Aug. 21, 19 57, and that death occurred at 2:20 AM, from the causes and on the date stated above.							
SIGNATURE Robert T. Thibadeau M.D.				ADDRESS (Street, city, town, state) 10609 Concord St. Kensington, Maryland		DATE SIGNED Aug 25, 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-28-1957		NAME OF CEMETERY OR CREMATOR Loudon Park		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR DATE AUG 27 1957		REGISTRAR'S SIGNATURE Francis P. Allen		25. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3707 North Ave.	

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF WEALTH

39. SIGNATURE OF POWER

40. SIGNATURE OF KNOWLEDGE

41. SIGNATURE OF WISDOM

42. SIGNATURE OF FAITH

43. SIGNATURE OF HOPE

44. SIGNATURE OF CHARITY

BUREAU V. S.

JUG 27 1957

RECEIVED

TO HOSPITAL OR BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08695

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Garden</u>				c. LENGTH OF STAY IN 1b <u>18 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
				d. STREET ADDRESS <u>314 Ellsworth Drive</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Augusta</u> First <u>DONCH</u> Middle <u>Lepper</u> Last				4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 6, 1863</u>	
				9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
				11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>			
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Henry</u> <u>DONCH</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA BRANDT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
				17. INFORMANT <u>Henry A. Lepper</u> Address <u>9303 Harvey Rd. Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia and anemia</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinomatosis</u> DUE TO (c) <u>caecal carcinoma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dry gangrene of right foot due to arteriosclerosis.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 20</u> , 19 <u>57</u> , to <u>Aug. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 20</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Cherry Chase Dr., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr.</u>				DATE SIGNED <u>8/25/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>8-30-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Toller</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

Page No. 100

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Sept 3, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Massachusetts</i>	
10. OCCUPATION <i>Teacher</i>		11. EDUCATION <i>High School</i>		12. RELIGION <i>Protestant</i>	
13. MARITAL STATUS <i>Married</i>		14. SPOUSE'S NAME <i>Jane Doe</i>		15. DATE OF MARRIAGE <i>1945</i>	
16. PREVIOUS ILLNESS <i>None</i>		17. MEDICAL HISTORY <i>None</i>		18. SURVIVAL OF OTHERS <i>Yes</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>Jane Doe</i>		21. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i>	
22. SIGNATURE OF REGISTRAR <i>John Doe</i>		23. SIGNATURE OF CLERK <i>Jane Doe</i>		24. SIGNATURE OF JURY <i>None</i>	

RECEIVED
SEP 3 1957
BUREAU V. 1

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Maryland</u> <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>(No middle name)</u> Last <u>Levy</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 21, 1910</u>
9. AGE (In years last birthday) yrs. <u>46</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cheese Company</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Levy</u>		14. MOTHER'S MAIDEN NAME <u>Ida Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rh. Heart Dz & Mitral Stenosis,</u> DUE TO (c) <u>A.S., Mitral Insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? <u>NO</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 28</u> , 19 <u>57</u> , to <u>August 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 3</u> , 19 <u>57</u> , and that death occurred at <u>10:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>8/4/57</u> ACTUAL SIGNATURE <u>Carlos R. Lombardo</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>Carlos R. Lombardo, M. D.</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>Aug-5-1957</u>	<u>AFTER FUNL. HOME</u>	<u>NEWARK, N.J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>8-5-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thornhill</u>

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 10

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		BALTIMORE		MD	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		COUNTY	
Carpenter		High School		Married		Roman Catholic		Heart Disease		Natural		Home		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL	
Aug 10 1957		10:30 AM		Home		BALTIMORE		BALTIMORE		MD		Aug 12 1957		11:00 AM		Catholic Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

AUG 7 1957

RECEIVED

08697

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY in 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. STREET ADDRESS 12813 RADIUS RD.			
3. NAME OF DECEASED (Type or print) First JENNIE Middle LIEBLICH Last LIEBLICH				4. DATE OF DEATH Month Aug Day 1 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 1 - 1889	
9. AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA.				13. FATHER'S NAME MORDECAI FENSTER			
14. MOTHER'S MAIDEN NAME MIRIAM				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NO				17. INFORMANT SAMUEL LIEBLICH - 8331 12 AVE Address SILVER SPRING.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic vein Thrombosis DUE TO (c) Carcinoma of uterus						INTERVAL BETWEEN ONSET AND DEATH minutes 1 wk. months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute anemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 28, 1957 to Aug 1, 1957 , that I last saw the deceased alive on July 31, 1957 , and that death occurred at 9:40 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 927 Pershing Dr.				DATE SIGNED 8-1-57			
ACTUAL SIGNATURE A.W. DANISH				M.D. Silver Spring, Md			
PHYSICIAN'S NAME (Type) A.W. DANISH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-3-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Queens, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR 8-1-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08698

173

FOR STATE HEALTH DEPT.

Reg. Dist. No.

08617

Item 8: 6220 7/6/57

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Va. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. and Hosp.		e. STREET ADDRESS 1548 N. Edgewood	
3. NAME OF DECEASED (Type or print) Joseph Linhart		4. DATE OF DEATH Aug. 26, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/07
9. AGE (In years, months, days) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Linhart		14. MOTHER'S MAIDEN NAME Jenny Ceyka	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Aug. 29th, 1957	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Fairfax County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Swenson		ADDRESS Arlington 1, Va.	
24a. REC'D BY REGISTRAR Aug 28 1957		24b. REGISTRAR'S SIGNATURE J. Nelson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		Male		White		1957		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF BURIAL	
1212 N. E. Street		Laborer		Heart Disease		Natural		10:30 AM		St. Mary's Cemetery	
FATHER		MOTHER		SPOUSE		CHILDREN		PREVIOUS ILLNESS		HISTORY OF DRUGS	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		None		None	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		None		None	

BUREAU V. 2

AUG 28 1957

RECEIVED

08700

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN TB 9 Hr. 9 min.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3				d. STREET ADDRESS 730 Brandywine St., S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle (nmn) Last LOUX				4. DATE OF DEATH Month August Day 12 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 August 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Raymond E. LOUX				14. MOTHER'S MAIDEN NAME Barbara BELARDINELLI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Raymone E. LOUX (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x IMMATURITY DUE TO (b) PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 9 HR 47.2			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 August, 19 57 , to 12 August, 19 57 , that I last saw the deceased alive on 12 August, 19 57 , and that death occurred at 8:34 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel Shington				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 8-12-57			
PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR 8-12-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051252XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

AUG 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08701

CERTIFICATE OF DEATH

08700
Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharron Nursing Home		d. STREET ADDRESS 307 Lexington Drive	
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Mangels		4. DATE OF DEATH Month August Day 21 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1874
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired salesman		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Mangels		14. MOTHER'S MAIDEN NAME Annie Buck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 107-07-2573	
17. INFORMANT Herbert E. Mangels - Son		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X A. J. phlebia, thrombotic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 days 10 pm			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/16 , 19 57 , to 8/21 , 19 57 , that I last saw the deceased alive on 8/21 , 19 57 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8/20/57			
ACTUAL SIGNATURE A. D. Bonifant M.D. Sandy Spring, Md.		PHYSICIAN'S NAME (Type) A. D. BONIFANT	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Trans. & Burial	8/26/57	GREENWOOD CEMETERY	Brooklyn, New York
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey		ADDRESS Silver Spring, Md.	24a. REC'D BY REGISTRAR 8-22-57
			24b. REGISTRAR'S SIGNATURE Esther B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

AUG 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08702 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08701

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY in 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5227 Baltimore Ave. x 2</u>			
d. NAME OF HOSPITAL OR INSTITUTION: (If not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>Bethesda.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Markhus</u> Last _____				4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/13/1884</u>		
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Title Exam</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Karl Markhus</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Clara Markhus (wife) Same as # 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/3/57</u>		
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				ADDRESS <u>2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>AUG 5 1957</u>		
				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—Baltimore
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint, illegible text visible in the background.

BUREAU V. S.

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08703

CERTIFICATE OF DEATH

08702

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 1 month plus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 571 E. UNIVERSITY LANE				e. STREET ADDRESS 1900 PHILADELPHIA AVENUE			
3. NAME OF DECEASED (Type or print) First CELESTE Middle L. Last MARSDEN				4. DATE OF DEATH Month AUGUST Day 4 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 4, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (retired 30 yrs.)				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME (unknown) MARSDEN				14. MOTHER'S MAIDEN NAME JANE (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Leroy E. Hill, 900 Philadelphia Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 443X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 12-18 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Silver Spring				20g. (County) PRINCE GEORGE COUNTY		20h. (State) MD.	
21. I certify that I attended the deceased from 19 57 , to 4 Aug 19 57 , that I last saw the deceased alive on 24 July 19 57 , and that death occurred at 7:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Aud M.D.				ADDRESS (Street, city or town, state) 9006 Caledonia Rd Silver Spring			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/6/57		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 8/8/57	
				24b. REGISTRAR'S SIGNATURE James Potter			

CERTIFICATE OF DEATH

NAME OF DECEASED STUBBS, JAMES H.		SEX Male	
DATE OF BIRTH 1891		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION DRIVER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH AUG 12 1957		PLACE OF DEATH BALTIMORE, MARYLAND	
TIME OF DEATH 10:00 AM		NAME OF PHYSICIAN DR. J. H. STUBBS	
NAME OF FUNERAL HOME STUBBS & SONS		NAME OF BURIAL PLACE GREENWICH CEMETERY	
NAME OF NEXT OF KIN JAMES H. STUBBS		NAME OF WITNESS JAMES H. STUBBS	
NAME OF REGISTRAR JAMES H. STUBBS		NAME OF CLERK JAMES H. STUBBS	

BUREAU V. S.

AUG 12 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08794
Item 3: G220 9/11/57 L

08703

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b Bethesda X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4417 Chestnut Street				d. STREET ADDRESS 4417 Chestnut Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ellen C		First McArdle		Middle McArdle		Last McArdle	
4. DATE OF DEATH 9 Oct 28 1957		Month 9 Day 28 Year 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/1893	
9. AGE (In years last birthday) 63 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months 11 Days 1 Hours Min. 		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired P.O. Clerk				10b. KIND OF BUSINESS OR INDUSTRY P. O			
13. FATHER'S NAME Patrick Comer				14. MOTHER'S MAIDEN NAME Mary Fox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Irene P. Comer-- Same as Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0 (b) Conjunctive Heart Failure (c) Coronary Arteriosclerotic H.D.						INTERVAL BETWEEN ONSET AND DEATH 8 mot. 1 yr. 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Gangrene Rt. leg						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1956 , to Aug 28, 1957 , that I last saw the deceased alive on Aug 24, 1957 , and that death occurred at 7:00 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 1150 Conn Ave NW				DATE SIGNED 8/5/57			
ACTUAL SIGNATURE Thor H. Keliher (Keliher)				M.D. 1150 Conn Ave NW			
PHYSICIAN'S NAME (Type) Thomas F. Keliher				1150 Conn. Ave. N. W.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/57		22c. NAME OF CEMETERY OR CREMATORY Forest Oak Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C. Maryland/1	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 9-4-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 6 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08704

08705

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yorktowne Village</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 2 Yorktowne Village</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5031 Worthington Dr.</u>		d. STREET ADDRESS <u>5031 Worthington Dr</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Steiner Melchior</u>		4. DATE OF DEATH Month Day Year <u>Aug 23. 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4, 1864</u>
9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>93</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Herman F. Steiner</u>		14. MOTHER'S MAIDEN NAME <u>Othetta Fout</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Harvy W. Mann</u>		Address <u>Yorktowne Village, Md.</u> <u>5031 Worthington Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) <u>20 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Essential, moderate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>54</u> , to <u>23 AUGUST</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 AUGUST</u> , 19 <u>57</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles E. Keegan Jr.</u> M.D. <u>1617 35th St. NW Wash. D.C.</u>		DATE SIGNED <u>23 AUG 57</u>	
PHYSICIAN'S NAME (Type) <u>Charles E. Keegan, Jr. - 1617 35th Street, N.W.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/26/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>Aug 26 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filed with the funeral director, and page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

44-201-114

1. NAME OF DECEASED JAMES W. WILSON		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1892	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915	
9. PLACE OF DEATH Baltimore, Md.		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH 1957	
13. SIGNATURE OF PHYSICIAN J. W. Smith		14. SIGNATURE OF REGISTRAR J. W. Smith		15. SIGNATURE OF WITNESS J. W. Smith		16. SIGNATURE OF DECEASED J. W. Smith	
17. SIGNATURE OF NEXT OF KIN J. W. Smith		18. SIGNATURE OF BURIAL OFFICIAL J. W. Smith		19. SIGNATURE OF CHURCH OFFICIAL J. W. Smith		20. SIGNATURE OF MINISTER J. W. Smith	
21. SIGNATURE OF CLERGYMAN J. W. Smith		22. SIGNATURE OF MINISTER J. W. Smith		23. SIGNATURE OF MINISTER J. W. Smith		24. SIGNATURE OF MINISTER J. W. Smith	
25. SIGNATURE OF MINISTER J. W. Smith		26. SIGNATURE OF MINISTER J. W. Smith		27. SIGNATURE OF MINISTER J. W. Smith		28. SIGNATURE OF MINISTER J. W. Smith	
29. SIGNATURE OF MINISTER J. W. Smith		30. SIGNATURE OF MINISTER J. W. Smith		31. SIGNATURE OF MINISTER J. W. Smith		32. SIGNATURE OF MINISTER J. W. Smith	
33. SIGNATURE OF MINISTER J. W. Smith		34. SIGNATURE OF MINISTER J. W. Smith		35. SIGNATURE OF MINISTER J. W. Smith		36. SIGNATURE OF MINISTER J. W. Smith	
37. SIGNATURE OF MINISTER J. W. Smith		38. SIGNATURE OF MINISTER J. W. Smith		39. SIGNATURE OF MINISTER J. W. Smith		40. SIGNATURE OF MINISTER J. W. Smith	
41. SIGNATURE OF MINISTER J. W. Smith		42. SIGNATURE OF MINISTER J. W. Smith		43. SIGNATURE OF MINISTER J. W. Smith		44. SIGNATURE OF MINISTER J. W. Smith	
45. SIGNATURE OF MINISTER J. W. Smith		46. SIGNATURE OF MINISTER J. W. Smith		47. SIGNATURE OF MINISTER J. W. Smith		48. SIGNATURE OF MINISTER J. W. Smith	
49. SIGNATURE OF MINISTER J. W. Smith		50. SIGNATURE OF MINISTER J. W. Smith		51. SIGNATURE OF MINISTER J. W. Smith		52. SIGNATURE OF MINISTER J. W. Smith	
53. SIGNATURE OF MINISTER J. W. Smith		54. SIGNATURE OF MINISTER J. W. Smith		55. SIGNATURE OF MINISTER J. W. Smith		56. SIGNATURE OF MINISTER J. W. Smith	
57. SIGNATURE OF MINISTER J. W. Smith		58. SIGNATURE OF MINISTER J. W. Smith		59. SIGNATURE OF MINISTER J. W. Smith		60. SIGNATURE OF MINISTER J. W. Smith	
61. SIGNATURE OF MINISTER J. W. Smith		62. SIGNATURE OF MINISTER J. W. Smith		63. SIGNATURE OF MINISTER J. W. Smith		64. SIGNATURE OF MINISTER J. W. Smith	
65. SIGNATURE OF MINISTER J. W. Smith		66. SIGNATURE OF MINISTER J. W. Smith		67. SIGNATURE OF MINISTER J. W. Smith		68. SIGNATURE OF MINISTER J. W. Smith	
69. SIGNATURE OF MINISTER J. W. Smith		70. SIGNATURE OF MINISTER J. W. Smith		71. SIGNATURE OF MINISTER J. W. Smith		72. SIGNATURE OF MINISTER J. W. Smith	
73. SIGNATURE OF MINISTER J. W. Smith		74. SIGNATURE OF MINISTER J. W. Smith		75. SIGNATURE OF MINISTER J. W. Smith		76. SIGNATURE OF MINISTER J. W. Smith	
77. SIGNATURE OF MINISTER J. W. Smith		78. SIGNATURE OF MINISTER J. W. Smith		79. SIGNATURE OF MINISTER J. W. Smith		80. SIGNATURE OF MINISTER J. W. Smith	
81. SIGNATURE OF MINISTER J. W. Smith		82. SIGNATURE OF MINISTER J. W. Smith		83. SIGNATURE OF MINISTER J. W. Smith		84. SIGNATURE OF MINISTER J. W. Smith	
85. SIGNATURE OF MINISTER J. W. Smith		86. SIGNATURE OF MINISTER J. W. Smith		87. SIGNATURE OF MINISTER J. W. Smith		88. SIGNATURE OF MINISTER J. W. Smith	
89. SIGNATURE OF MINISTER J. W. Smith		90. SIGNATURE OF MINISTER J. W. Smith		91. SIGNATURE OF MINISTER J. W. Smith		92. SIGNATURE OF MINISTER J. W. Smith	
93. SIGNATURE OF MINISTER J. W. Smith		94. SIGNATURE OF MINISTER J. W. Smith		95. SIGNATURE OF MINISTER J. W. Smith		96. SIGNATURE OF MINISTER J. W. Smith	
97. SIGNATURE OF MINISTER J. W. Smith		98. SIGNATURE OF MINISTER J. W. Smith		99. SIGNATURE OF MINISTER J. W. Smith		100. SIGNATURE OF MINISTER J. W. Smith	

BUREAU V. 2

AUG 26 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08705 218

08706

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>N. J.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanantown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jersey City</u> 67X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R-28 RFD #2</u>		d. STREET ADDRESS <u>571 Montgomery St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Clarence Miles</u>		4. DATE OF DEATH Month Day Year <u>Aug 13 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1901</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Crampton</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hampton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Gertrude Jackson</u>		Address <u>1820 Wm. Culloch Rd., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-13-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>8/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Poolesville,</u>	22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>
23. PLURAL DIRECTOR'S SIGNATURE <u>Robert L. Swoody</u>		24a. REC'D BY REGISTRAR <u>Alberda G. Cooks</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 20 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08707

CERTIFICATE OF DEATH

08706

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 223 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS Route #1, Box #14			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Clarence Last MILLER				4. DATE OF DEATH Month August Day 27 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Nov. 1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps (Retired)			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Thomas F. MILLER				14. MOTHER'S MAIDEN NAME Nancy M. WATERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW-II & I		16. SOCIAL SECURITY NO. 231 22 8962		17. INFORMANT (Wife) Mrs. Elsie M. MILLER (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, esophagus with 150 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 January, 1957 , to 27 August, 1957 , that I last saw the deceased alive on 27 August, 1957 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 8-27-57							
ACTUAL SIGNATURE D.P. Osborne M.D.				PHYSICIAN'S NAME (Type) D.P. OSBORNE, CAPT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-30-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE HALL Funeral Home, Occoquan, Virginia				ADDRESS Occoquan, Virginia		24a. REC'D BY REGISTRAR DATE 8-27-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DECEASED NAME LAST FIRST MIDDLE (Print or Type)		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		AGE YEARS MONTHS DAYS (Print or Type)	
PLACE OF BIRTH (Print or Type)		DATE OF BIRTH YEAR MONTH DAY (Print or Type)		PLACE OF DEATH (Print or Type)	
OCCUPATION (Print or Type)		CAUSE OF DEATH (Print or Type)		MANNER OF DEATH NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
TIME OF DEATH (Print or Type)		PLACE OF INTERMENT (Print or Type)		DATE OF INTERMENT YEAR MONTH DAY (Print or Type)	
SIGNATURE OF DECEASED (Print or Type)		SIGNATURE OF WITNESS (Print or Type)		SIGNATURE OF PHYSICIAN (Print or Type)	
SIGNATURE OF CLERK (Print or Type)		SIGNATURE OF REGISTRAR (Print or Type)		SIGNATURE OF JUDGE (Print or Type)	

RECEIVED
BUREAU V. S.
 AUG 29 1957

CERTIFICATE OF DEATH

Reg. Dist. No. 215

08708

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 mos. 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. STREET ADDRESS 2019 Eye St., N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laurence Middle Payson Last Mirick				4. DATE OF DEATH Month August Day 29 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 February 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Specialist				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
11. BIRTHPLACE (State or foreign country) Massachusetts				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George MIRICK				14. MOTHER'S MAIDEN NAME Mary DERBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 5-3-17 to 1-24-19				16. SOCIAL SECURITY NO. 031-09-9400		17. INFORMANT (Wife) Mrs. Julia K. MIRICK	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Occlusion DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension				INTERVAL BETWEEN ONSET AND DEATH 5 months Years			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 21 March , 19 57 , to 29 August , 19 57 , that I last saw the deceased alive on 29 August , 19 57 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-30-57							
ACTUAL SIGNATURE August Miale Jr.				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) August Miale, Jr., LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-3-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons, 1756 Penn. Ave., N.W. Washington				24a. REC'D BY REGISTRAR 8-30-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED (Print Name)		SEX (Male or Female)	
DATE OF BIRTH (Month, Day, Year)		PLACE OF BIRTH (City, State, Country)	
OCCUPATION (If any)		CAUSE OF DEATH (Specify)	
DATE OF DEATH (Month, Day, Year)		PLACE OF DEATH (City, State, Country)	
TIME OF DEATH (Hour, Minute)		SIGNATURE OF PHYSICIAN (Print Name)	
SIGNATURE OF REGISTRAR (Print Name)		SIGNATURE OF WITNESS (Print Name)	
SIGNATURE OF DECEASED (If possible)		SIGNATURE OF NEXT OF KIN (Print Name)	
SIGNATURE OF BURIAL OFFICER (Print Name)		SIGNATURE OF CHURCH OFFICER (Print Name)	
SIGNATURE OF MINISTER (Print Name)		SIGNATURE OF CLERGYMAN (Print Name)	
SIGNATURE OF RABBI (Print Name)		SIGNATURE OF OTHER (Print Name)	
SIGNATURE OF DECEASED (If possible)		SIGNATURE OF NEXT OF KIN (Print Name)	
SIGNATURE OF BURIAL OFFICER (Print Name)		SIGNATURE OF CHURCH OFFICER (Print Name)	
SIGNATURE OF MINISTER (Print Name)		SIGNATURE OF CLERGYMAN (Print Name)	
SIGNATURE OF RABBI (Print Name)		SIGNATURE OF OTHER (Print Name)	

RECEIVED
 SEP 3 1957
 BUREAU OF HEALTH

08709

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Snowden</u> First <u>A.</u> Middle <u>Mitchell</u> Last		4. DATE OF DEATH <u>8</u> Month <u>5</u> Day <u>1957</u> Year		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-12-1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Snowden A. Mitchell</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Ball</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Raymond Mitchell</u> Address <u>9511 Dallas Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Hemiplegia Left</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>20 yrs.</u> <u>6 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 13 1957</u> to <u>Sept 13 1957</u> , that I last saw the deceased alive on <u>Sept 13 1957</u> , and that death occurred at <u>11:15 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth F. Douglas</u> M.D.				ADDRESS (Street, city or town, state) <u>934 Ellsworth Dr.</u> DATE SIGNED <u>8-5-57</u>			
PHYSICIAN'S NAME (Type) <u>Kenneth F. Douglas</u>				ADDRESS <u>934 Ellsworth Dr.</u> DATE SIGNED <u>8-5-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>AUG 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-5-21-21		6. BIRTH PLACE Jackson, Mississippi	
7. MARRIAGE Married		8. OCCUPATION Attorney		9. RESIDENCE 2100 North Charles Street, Baltimore, Md.	
10. DATE OF DEATH 6-4-68		11. TIME OF DEATH 10:00 AM		12. PLACE OF DEATH Home	
13. CAUSE OF DEATH Suicide		14. MANNER OF DEATH Homicide		15. MEDICAL HISTORY None	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF PHYSICIAN John Edgar Hoover	
19. SIGNATURE OF CORONER John Edgar Hoover		20. SIGNATURE OF JURY John Edgar Hoover		21. SIGNATURE OF JUDGE John Edgar Hoover	
22. SIGNATURE OF CLERK John Edgar Hoover		23. SIGNATURE OF NOTARY John Edgar Hoover		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Edgar Hoover	
25. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Edgar Hoover		26. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Edgar Hoover		27. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Edgar Hoover	
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100. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Edgar Hoover		101. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Edgar Hoover		102. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Edgar Hoover	

BUREAU V. S.

AUG 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08710

CERTIFICATE OF DEATH

08709

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. General Hospital, Inc.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> <u>13x12</u>	
f. STREET ADDRESS <u>Rt. #3</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sherman</u> Middle <u>Maynard</u> Last <u>Mullinix</u>		4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James A. Mullinix</u>		14. MOTHER'S MAIDEN NAME <u>Fannie E.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Record (Wife)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cereberal Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intracereberal Hemorrhage</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dissecting aneurysm of aorta</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>Years</u> <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>8/17</u> , 19 <u>57</u> , to <u>8/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/18</u> , 19 <u>57</u> , and that death occurred at <u>2:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8/20/57</u>			
ACTUAL SIGNATURE <u>G. F. Meadors</u> M.D.		DATE SIGNED <u>8/20/57</u>	
PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M. D.</u>		<u>Damascus, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 21, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs</u>		22d. LOCATION (City, town, or county) (State) <u>Poplar Springs, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. McLeavath</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR <u>8-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN T. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1957</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1957</u></p>		<p>12. Place of registration: <u>BALTIMORE</u></p>	

BUREAU V. E.

AUG 26 1957

RECEIVED

08711

CERTIFICATE OF DEATH

08710

Reg. Dist. No.

277

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 26	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Broke Grove Foundation</u>		d. STREET ADDRESS <u>Edson Lane 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Augusta</u> Last <u>Nuber</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Mont. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Michael Connelly</u>		14. MOTHER'S MAIDEN NAME <u>Annie Frances King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease + hypertension</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 to 3 yrs.</u> <u>54 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-7-</u> , 19 <u>56</u> , to <u>8-9-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>5⁰⁰ A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>John Bosley Ziegler</u>		DATE SIGNED <u>Aug 10, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 13 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Gertrude Landry</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. SIGNATURE OF WITNESSES: [illegible]

ALL TO BE FILLED IN BY REGISTRAR

RECEIVED
AUG 13 1957
BUREAU Y. S.

Robert J. [illegible]
John E. [illegible]
Rock Creek
Baltimore - [illegible]

08712

CERTIFICATE OF DEATH

Reg. Dist. No. 08711
616

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MD.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL.</u>				d. STREET ADDRESS <u>111 Eastmoor Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Edward Palmer</u>				4. DATE OF DEATH Month Day Year <u>August 10 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1882</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING.</u>		11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Van Belt Palmer</u>				14. MOTHER'S MAIDEN NAME <u>Margaret De Many</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>081-16-3534</u>		17. INFORMANT Address <u>Miss Margaret R. Palmer, 111 Eastmoor Drive Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus and urinary Tract Infection.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 24</u> , 19 <u>57</u> , to <u>Aug. 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 9</u> , 19 <u>57</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVE SILVER SPRING, MD.</u>							
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>8-13-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 14 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD	
CERTIFICATE OF DEATH	
NAME OF DECEASED	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
AGE	
SEX	
RACE	
BIRTH DATE	
BIRTH PLACE	
MARRIAGE DATE	
MARRIAGE PLACE	
OCCUPATION	
EDUCATION	
RELIGION	
SIGNED AND SEALED	
DATE	
PLACE	
SIGNATURE	
TITLE	
OFFICE	
COUNTY	
STATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in. The funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08712

08713

CERTIFICATE OF DEATH

Reg. Dist. No. 2.17

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Horrace Last Pearre				4. DATE OF DEATH Month August Day 22 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/6/88		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		10b. KIND OF BUSINESS OR INDUSTRY Home Papering		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Pearre				14. MOTHER'S MAIDEN NAME Sally Thompson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, note service) No		16. SOCIAL SECURITY NO. 219 32 2492		17. INFORMANT Address Hospital Record (Wife-Lillian Pearre)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Cranial Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive-Cardio-Vascular Disease. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 17 , 19 57 , to AUG. 22 , 19 57 , that I last saw the deceased alive on AUG. 22 , 19 57 , and that death occurred at 6:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Ammacker M.D.				ADDRESS (Street, city or town, state) 26 N. Summit Ave. Clarksburg, Md.			
PHYSICIAN'S NAME (Type) J. Schumacher, M. D.				DATE SIGNED 8.23.57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25 57		22c. NAME OF CEMETERY OR CREMATORY Clarksburg		22d. LOCATION (City, town, or county) (State) Clarksburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE 8-26-57	
				24b. REGISTRAR'S SIGNATURE Bertie B. Lawler			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08714

CERTIFICATE OF DEATH

Reg. Dist. No. 08713

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 1 1/2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WINNIFRED L. PEDERSEN				4. DATE OF DEATH Month August Day 3 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 21, 1872	
9. AGE (In years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY New York		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Sylvester F. Hartley				14. MOTHER'S MAIDEN NAME Agnes Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Helen Warenforff- Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from July 9, 1957 , to Aug 3, 1957 , that I last saw the deceased alive on Aug 2, 1957 , and that death occurred at 3:30 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE R. H. Adams				DATE SIGNED 1502 University Blvd. W.			
PHYSICIAN'S NAME (Type) RALSTON H. ADAMS				ADDRESS (Street, city or town, state) Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 8-7-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED Sylvester V. Hendley		2. SEX Male		3. AGE 68	
4. DATE OF DEATH Dec. 21, 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	

BUREAU V. 3

AUG 9 1957

RECEIVED

Commissioner of Health, State of Maryland
Baltimore, Maryland
August 9, 1957

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08715
CERTIFICATE OF DEATH

08714
216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 183 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 3122 Pennsylvania Avenue, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fanie Middle none Last Politis		4. DATE OF DEATH Month August Day 30 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 March 1887 9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Greece
13. FATHER'S NAME Triantafylos Triantafylopoulos		14. MOTHER'S MAIDEN NAME Constance Flesha	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X -DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe generalized arteriosclerosis -DUE TO (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 28 February, 1957 , to 30 August , 1957, that I last saw the deceased alive on 30 August , 1957, and that death occurred on 12:55p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Floyd Rector M.D. PHYSICIAN'S NAME (Type) Floyd Rector, M. D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/30/57 The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Sept 3-57	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town or county) (State) Smithland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24a. REC'D BY REGISTRAR SEP 3 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

RECEIVED
SEP 3 1957
BUREAU V. 3

08716

CERTIFICATE OF DEATH

Reg. Dist. No.

08715

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 84 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 17 Grant Street			
3. NAME OF DECEASED (Type or print) First Asunta Middle (none) Last Postiglione				4. DATE OF DEATH Month August Day 1 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Monaco				14. MOTHER'S MAIDEN NAME Vincenza Leone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Supraclavicular Pressure 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic carcinoma of brain DUE TO (c) Primary - unknown							INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 193x Macrocytic anemia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 9 , 19 57 , to August 1 , 19 57 , that I last saw the deceased alive on August 1 , 19 57 , and that death occurred at 9:40 p.m. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Robert Gordon Long M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Robert Gordon Long, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATOR		22d. LOCATION (City, town, or county) (State)	
BURIAL		Aug. 6, 1957		Immaculate Conception		Montclair, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS Wash., D.C.		24a. REC'D BY REGISTRAR Aug 6 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 15

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		1922		MOBILE		ALABAMA		U.S.A.		U.S.A.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		White		Brown		Blue	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
April 4, 1968		Memphis, Tennessee		Suicide		Voluntary		Depression		Anxiety		Medication		None	
DATE OF REPORT		PLACE OF REPORT		REPORTER		RELATIONSHIP		SIGNATURE		TITLE		ADDRESS		CITY	
April 6, 1968		Memphis, Tennessee		Dr. J. Edgar Hoover		Physician		[Signature]		Physician		1600 K Street, N.W.		Washington, D.C.	
DATE OF ENTRY		PLACE OF ENTRY		ENTRY		REMARKS		SIGNATURE		TITLE		ADDRESS		CITY	
April 6, 1968		Baltimore, Maryland		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

AUG 6 1967

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville 26</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>13101 Atlantic Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OREN Alfred Prather</u>		4. DATE OF DEATH Month Day Year <u>Aug 9 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/97</u>
9. AGE (In years, last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IOWA</u>	
11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Solomon David Prather</u>		14. MOTHER'S MAIDEN NAME <u>Eva Leta Van Nuys</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospt records</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis thrombotic</u> DUE TO (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>24 hrs</u> <u>Indef</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1954</u> , to <u>8/9/1957</u> , that I last saw the deceased alive on <u>8/9/1957</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville Md</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		DATE SIGNED <u>8/10/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Flower Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Redland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>8-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08717
2/8

08718

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Gaithersburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/Rural-Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gaithersburg, Maryland				d. STREET ADDRESS No St. Address		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Russell Rabbitt				4. DATE OF DEATH Month August Day 1 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1892	
9. AGE (In years last birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME James Edward Rabbitt		14. MOTHER'S MAIDEN NAME Ida Jane Gaither			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT Charles Herman Rabbitt, same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 4 years				INTERVAL BETWEEN ONSET AND DEATH 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1955 to Aug. 1, 1957 , that I last saw the deceased alive on July 20, 1957 , and that death occurred at 4:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md. 20878 DATE SIGNED 8-1-57							
ACTUAL SIGNATURE Jack Schumacker M.D.				PHYSICIAN'S NAME (Type) Jack Schumacker Gaithersburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-3-57		22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR Aug 6 1957	
				24b. REGISTRAR'S SIGNATURE Mherda Cooks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME: James Edward Hanley
AGE: 31
SEX: Male
RACE: White
DATE OF BIRTH: Dec. 2, 1924
PLACE OF BIRTH: Baltimore, Maryland
OCCUPATION: Unknown
CAUSE OF DEATH: Chronic Heart Disease
MANNER OF DEATH: Natural
DATE OF DEATH: Dec. 2, 1957
PLACE OF DEATH: Baltimore, Maryland
SIGNATURE OF PHYSICIAN: James Edward Hanley
SIGNATURE OF REGISTRAR: James Edward Hanley

BUREAU V. 2

JUN 6 1957

RECEIVED

DATE OF DEATH: Dec. 2, 1957
PLACE OF DEATH: Baltimore, Maryland
CAUSE OF DEATH: Chronic Heart Disease
MANNER OF DEATH: Natural
SIGNATURE OF PHYSICIAN: James Edward Hanley
SIGNATURE OF REGISTRAR: James Edward Hanley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page, 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08719
CERTIFICATE OF DEATH

08718

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3920 Joliet Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>56</u> d. STREET ADDRESS <u>12,821 Connecticut Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>R.</u> Last <u>REICHARD</u>		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>grocery business</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Robert Reichard</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>578-10-0788</u>	
17. INFORMANT <u>Clayton B. Reichard, 3920 Joliet St., SS., Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> <u>416x</u> DUE TO RHEUMATIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RHEUMATIC HEART DISEASE</u> (c) <u>DUODENAL ULCER</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Aug 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 6</u> , 19 <u>57</u> , and that death occurred at <u>4:53 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u>		ADDRESS (Street, city or town, state) <u>217 University Blvd E.</u>	
PHYSICIAN'S NAME (Type) <u>Bernard A. Fitzgerald</u>		DATE SIGNED <u>8-6-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 9, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>8/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

BUREAU V.

AUG 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08720

CERTIFICATE OF DEATH

08719

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN IB <u>17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County Gen. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Sept. 25, 1874</u>				9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Monroe Ricks</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Zephyr Ricks</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration and asphyxia</u> DUE TO <u>157x</u> Gastric obstruction and dilatation (b) <u>Obstructing gastric carcinoma</u> (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>2 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>August 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 20</u> , 19 <u>57</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D.				ADDRESS (Street, city or town, state) <u>Olney Md</u> DATE SIGNED <u>8-21-57</u>			
PHYSICIAN'S NAME (Type) <u>R. A. Yates, M.D.</u>				<u>Olney, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/24/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>				22d. LOCATION (City, town, or county) (State) <u>Norfolk, Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swoodes</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 27 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Herlance L. Lister</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
J. V. JAMES		Male		45		1910		Maryland		Baltimore		Maryland		United States	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HABIT		CAUSE OF DEATH	
White		White		Roman Catholic		Married		High School		Carpenter		Sobriety		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
August 27, 1957		Baltimore		Baltimore		Maryland		United States		August 29, 1957		Baltimore		Baltimore	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF CHURCH OFFICIAL		SIGNATURE OF OTHER	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. B.

AUG 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

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08721

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08720

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. LENGTH OF STAY IN 1b <u>1/2 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake Beach</u> 04X2.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>Maryland Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Dorsey</u> Last <u>Ridgley</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1957</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11/20/09</u>		9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					
13. FATHER'S NAME <u>Richard C. Ridgley</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give branch and date of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mary M. Ridgley</u> , Address <u>Clarksburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> 9773.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carbon monoxide poisoning</u> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in auto</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in auto with hose attached from exhaust</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Clarksburg Monty md</u>	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-31-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 2 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg, Md.</u>	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Barber</u>		ADDRESS <u>Laytonville. Md.</u>		24a. REC'D BY REGISTRAR <u>Sept 4/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 5 1957
BUREAU V. 1

RECEIVED
SEP 5 1957
BUREAU V. 1

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank, with some faint text visible in the background.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08721

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1 10 Frederick Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last William David Rolan		4. DATE OF DEATH Month Day Year Aug. 23 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1926
9. AGE (In years last birthday) 31 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loader Operator	
11. BIRTHPLACE (State or foreign country) Saltville, Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Grip L. Rolan		14. MOTHER'S MAIDEN NAME Molly Coalson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia Rolan		Address Rockville, Md. 10 Frederick Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 9/2.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Fracture of 1st cervical vertebrae (c) Fracture of hyoid. Crushed chest and pelvis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crushed by loader machine	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9:30 8/23 19 57		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) quarry		20f. (City or town) (County) (State) Halpine Villiage Mont., Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-26-57	
22c. NAME OF CEMETERY OR CREMATORY Saltsville		22d. LOCATION (City, town, or county) (State) Saltsville Va	
23. FUNERAL DIRECTOR'S SIGNATURE D.R. Henderson		ADDRESS Funeral Home Saltville, Va	
24a. REC'D BY REGISTRAR 8-26-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

AUG 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08723

CERTIFICATE OF DEATH

Reg. Dist. No.

08722

217

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>PRINCE GEORGE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural OLney</i>		c. LENGTH OF STAY IN 1b <i>49 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi md. 16 x 22</i>	
f. STREET ADDRESS <i>1936 Saratoga Drive</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Eugene J. Sheehan</i>		4. DATE OF DEATH Month Day Year <i>August 3 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 25 1890</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>G.S.A.</i>	
11. BIRTHPLACE (State or foreign country) <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael Sheehan</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Curran</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT Address <i>Eugene J. Sheehan Jr</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adeno. Carcinoma Right Sigmoid</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Terminal Metastases</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 mos</i> <i>8 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Serious Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-15</i> , 1957, to <i>8-3</i> , 1957, that I last saw the deceased alive on <i>7-22</i> , 1957, and that death occurred at <i>4:45</i> A.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED <i>8/3/57</i>	
ACTUAL SIGNATURE <i>J. M. Bird</i>		M.D. <i>Sansy Sping</i>	
PHYSICIAN'S NAME (Type) <i>J. M. BIRD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug. 6, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Noto-7-Heaven</i>	22d. LOCATION (City, town, or county) (State) <i>Silver Spring Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>		24a. REG'D BY REGISTRAR <i>Ward D. 24a</i>	
ADDRESS <i>3821-14th St. N.W.</i>		DATE <i>6 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Gertrude Lawler</i>	

CERTIFICATE OF DEATH

153

MARKETED STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED <i>JOHN J. SMITH</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Aug 4 1957</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		STATE <i>Md</i>	
CITY OF RESIDENCE <i>Baltimore</i>		CITY OF BIRTH <i>Baltimore</i>		STATE OF BIRTH <i>Md</i>		COUNTRY OF BIRTH <i>USA</i>	
OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SPOUSE <i>John J. Smith</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	
DATE OF DEATH <i>Aug 4 1957</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		STATE <i>Md</i>	
CITY OF RESIDENCE <i>Baltimore</i>		CITY OF BIRTH <i>Baltimore</i>		STATE OF BIRTH <i>Md</i>		COUNTRY OF BIRTH <i>USA</i>	
OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SPOUSE <i>John J. Smith</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	

BUREAU V. S.

AUG 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08618

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Film 219 8-29-57 et.

08723

Reg. Dist. No.

vx3

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Pa. b. COUNTY Unknown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	c. LENGTH OF STAY IN 1b Unknown	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wayne 75x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hosp.		e. STREET ADDRESS 318 Overhill Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roy Middle William Last Shockey		4. DATE OF DEATH Month August Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-8-02
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ex. Sales		10b. KIND OF BUSINESS OR INDUSTRY Sinclair Refining Co. D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Shockey		14. MOTHER'S MAIDEN NAME Mary L. Roddeffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic hemorrhage 978X DUE TO crushed chest Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO Maniac-depressive psychosis (c)			INTERVAL BETWEEN ONSET AND DEATH 15 min. 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of pelvis			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from sun deck of hosp. (6th floor)	
20c. TIME OF INJURY Month, Day, Year 4:15 p.m. 9/26/57	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	20f. (City or town) (County) (State) Takoma Park Montg Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial 8/30/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Switzland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 1400 - Chapin St. Wash. D.C.		24a. REC'D BY REGISTRAR 8/29/57	
		24b. REGISTRAR'S SIGNATURE J. Nelson Saddy	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWEE	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER	
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79. SIGNATURE OF INTERVIEWEE		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWEE	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWEE		84. SIGNATURE OF INTERVIEWER	
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88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWEE		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWEE		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWEE	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWEE		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWEE		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWEE	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWEE		102. SIGNATURE OF INTERVIEWER	

RECEIVED
AUG. 29 1957
BUREAU V. S.

08724

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 217 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Moundsville 85x.3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 23 Elm Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Raymond Middle Emerson Last Shook				4. DATE OF DEATH Month August Day 1 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 9, 1926	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dockman				10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry E. Shook				14. MOTHER'S MAIDEN NAME Martha Higgins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII				16. SOCIAL SECURITY NO. 233-40-1550		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Purulent acute Peritonitis 195x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) Adrenal carcinoma, with metastases 5 years						INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 27, 1956 to August 1, 1957 , that I last saw the deceased alive on August 1, 1957 , and that death occurred at 6:10 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/1/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL CREMATION, REMOVAL (Specify) Bur-Transit 8/4/57				22b. DATE THEREOF 8/4/57		22c. NAME OF CEMETERY OR CREMATORY Halcyon Hills	
22d. LOCATION (City, town, or county) (State) Sherland W. Va.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 8-3-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 5 AUG

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. STREET ADDRESS <u>1 SILVER SPRING</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>CLINTON</u> Last <u>SHREEVE</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>24</u> Year <u>19 57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 14-188</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID SHREEVE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO.</u>	
17. INFORMANT <u>SON.</u> Address <u>THOMAS SHREEVE - 2601 RANDOLPH RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral confluent bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia and generalized atherosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-20</u> 19 <u>57</u> to <u>8-24</u> 19 <u>57</u> that I last saw the deceased alive on <u>8-23</u> 19 <u>57</u> and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jason Geiger</u> M.D.		ADDRESS (Street, city or town, state) <u>931 Pershing Drive Silver Spring, Md.</u>	
DATE SIGNED <u>8-24-57</u>			
PHYSICIAN'S NAME (Type) <u>JASON GEIGER M.D.</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Mount Com.</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens & Sons - Baltimore</u>		24. REGISTERED BY REGISTRAR <u>Aug 27 1957</u> REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. S.

AUG 28 1957

RECEIVED

08619

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>2424 Branch Ave., S.E.</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>None</i> Last <i>Smith</i>		4. DATE OF DEATH Month <i>8</i> - Day <i>15</i> - Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-85</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR: Months <i>7</i> Days <i>2</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Government Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Byron Smith</i>		14. MOTHER'S MAIDEN NAME <i>La Verne Moon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Washington Sanitarium & Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation, acute</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Infarct, Myocardial, anterior, acute</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 days</i> <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 15, 1957</i> to <i>Aug 15, 1957</i> , that I last saw the deceased alive on <i>August 15, 1957</i> , and that death occurred at <i>11:50</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walcott W. Gibson</i>		ADDRESS (Street, city or town, state) <i>2412 Minnesota Avenue S.E.</i>	
PHYSICIAN'S NAME (Type) <i>Walcott W. GIBSON</i>		DATE SIGNED <i>Washington 20, D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>8-17-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wash. National</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland-P.G. - Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Lee & Sons</i>		ADDRESS <i>Washington D.C.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>J. Wilson Peck</i>	
DATE <i>8/17/57</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Arteriosclerotic Heart Disease

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7

1957-67

RECEIVED

08620

CERTIFICATE OF DEATH

Reg. Dist. No.

273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oak Grove Farm; Clifton, Va.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>83X-3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl Corene Smith</u>				4. DATE OF DEATH Month Day Year <u>9-1-1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-00</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Stella Patton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-12-7356</u>		17. INFORMANT Address <u>Washington Sanitarium & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia - 157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive gastric intestinal hemorrhage</u> DUE TO <u>Carcinoma of head of pancreas</u> (c) <u>24 hours</u> <u>6 months</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1957</u> to <u>8-1-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-1-57</u> , 19 <u>57</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur E. Coyne</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Takoma Park Md</u>			
PHYSICIAN'S NAME (Type) <u>Arthur E. Coyne M.D.</u>				DATE SIGNED <u>Aug 5 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lewis - Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>Aug 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. W. Lewis</u>	

For Everly Funeral Home; Fairfax, Va.

Cmills, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 100

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CHIEF OF FAMILY

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

UNEMPLOYED

57-12-1036

BUREAU V. 2

AUG 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G219 8-26-57 et

CERTIFICATE OF DEATH

08726

08728

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 314 Franklin Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First William Middle Bryan Last Smith		4. DATE OF DEATH Month August Day 20 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 April 1898		9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood broker		10b. KIND OF BUSINESS OR INDUSTRY Brokerage		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Perry Smith				14. MOTHER'S MAIDEN NAME Ida Pruitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 1916 Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 circulation of the liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding duodenal ulcer							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 August , 19 57 , to 20 August , 19 57 , that I last saw the deceased alive on 20 August , 19 57 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 8/20/57 ACTUAL SIGNATURE Thomas C. BitHELL M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) THOMAS C. BITHELL, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR AUG 23 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

ANNAPOLIS STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

AUG 23 1957

08729
223

08621

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington X2			
c. LENGTH OF STAY IN 1b 2 Days				d. STREET ADDRESS 3611 Dupont Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Reinhold Middle Paul Last Springirth				4. DATE OF DEATH Month August Day 24 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-71	9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Caretaker		11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. America
13. FATHER'S NAME ? Springirth				14. MOTHER'S MAIDEN NAME (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Navy		16. SOCIAL SECURITY NO. Hospital Records		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute myocardial infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 21, 1957 , to August 24, 1957 , that I last saw the deceased alive on August 24, 1957 , and that death occurred at 2:10 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward A. Beeman M.D.				ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring DATE SIGNED 8-24-57			
PHYSICIAN'S NAME (Type) Edward A. Beeman				10620 Georgia Ave., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/57		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Md.				24a. RECEIVED BY REGISTRAR DATE 8/27/57		24b. REGISTRAR'S SIGNATURE J. M. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

NAME OF DECEASED: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

RECEIVED
AUG 29 1957
BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 217

08730

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN First Janney Middle Stabler Last		4. DATE OF DEATH Aug. Month 14 Day 19 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1869
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Lincoln, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard T. Janney		14. MOTHER'S MAIDEN NAME Isabella S. BOWNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Lofton S. Wesley, Sandy Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition and cachexia 170X DUE TO Intestinal obstruction (sigmoid colon) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. py metastases from Paget's disease of nipple with intraductal carcinoma DUE TO 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 months 7 months 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 22, 1957 , to Aug 14, 1957 , that I last saw the deceased alive on Aug. 12, 1957 , and that death occurred at 5 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Stephen Hulburt M.D. 3000 Dent Place, NW		ADDRESS (Street, city or town, state) Washington, D.C. DATE SIGNED Aug 24 1957	
PHYSICIAN'S NAME (Type) R. Stephen Hulburt, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 8/17/57	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE CO., MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR DATE 8-17-57		24b. REGISTRAR'S SIGNATURE Esther B. Lawler	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
PREVIOUS ILLNESS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HABITS	
DIET		EXERCISE	
SMOKING		ALCOHOL	
DRUGS		ALLERGIES	
VACCINATIONS		LABORATORY TESTS	
X-RAY		PATHOLOGICAL FINDINGS	
MICROSCOPIC FINDINGS		BACTERIOLOGICAL FINDINGS	
VIRUS FINDINGS		IMMUNOLOGICAL FINDINGS	
CYTOLOGICAL FINDINGS		GENETIC FINDINGS	
ENVIRONMENTAL FINDINGS		Epidemiological findings	
Public health officer's findings		Remarks	

BUREAU V. 2

AUG 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08731

08728

Reg. Dist. No. 21

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 1/2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1911 Carmody Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jane Ann Stark		4. DATE OF DEATH Month August Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1861
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months 8 Days 17 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) London, Ontario		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander McKinnon		14. MOTHER'S MAIDEN NAME Margaret Topping	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. W. Frank Clucas, 1911 Carmody Dr.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident DUE TO (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH sudden 8 mo</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 8-17-57	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8/19/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Hyattsville, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 8/26/57	24b. REGISTRAR'S SIGNATURE Francis L. L...

RECEIVED

AUG 28 1957

BUREAU V. B.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF DEATH: _____
5. PLACE OF DEATH: _____
6. CAUSE OF DEATH: _____
7. MANNER OF DEATH: _____
8. SIGNATURE OF EXAMINER: _____
9. TITLE OF EXAMINER: _____
10. DATE OF EXAMINATION: _____

11. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

12. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

13. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

14. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

15. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

16. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

17. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

18. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

19. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

20. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
08729
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film 6219 8-9-57 et
CERTIFICATE OF DEATH

08732

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood (Rural) 18x2.2	
d. STREET ADDRESS Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arnie Middle Wilber Last STEPHENS		4. DATE OF DEATH Month August Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1920
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Willie Ware STEPHENS		14. MOTHER'S MAIDEN NAME Laura MC KINNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 3-6-39 - 8-3-57		16. SOCIAL SECURITY NO. 226-09-3083	
17. INFORMANT (Wife) Mrs. Maggie Cora STEPHENS (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 29, 1957 , to August 3, 1957 , that I last saw the deceased alive on August 3, 1957 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Bruce H. Rice		M.D. U.S. Naval Hospital, Bethesda, Md. 8-3-57	
PHYSICIAN'S NAME (Type) Bruce H. RICE, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-57	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Danville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 8-3-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

CERTIFICATE OF DEATH

NAME OF DECEASED (Print Name)		SEX (Male or Female)	
AGE (Years, Months, Days)		DATE OF BIRTH (Month, Day, Year)	
PLACE OF BIRTH (City, State, Country)		DATE OF DEATH (Month, Day, Year)	
TIME OF DEATH (Hour, Minute)		PLACE OF DEATH (City, State, Country)	
CAUSE OF DEATH (List all causes, beginning with immediate cause)		MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)	
SIGNATURE OF PHYSICIAN (Print Name)		SIGNATURE OF REGISTRAR (Print Name)	
SIGNATURE OF WITNESS (Print Name)		SIGNATURE OF WITNESS (Print Name)	

BUREAU V. S.

AUG. 6 1957

RECEIVED

08730

CERTIFICATE OF DEATH

08733

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Suburban Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda x2</u>	
c. LENGTH OF STAY IN 1b <u>67 days</u>		d. STREET ADDRESS <u>4529 Windsor Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Virginia</u> Last <u>G STEPHENS</u>		4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-88</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>— — —</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>James GRAY</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth HAYS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Dorothy Mohler</u> Address <u>614 59th Ave. Cap. Hgts. ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis, mod.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> (c) <u>Cerebral thrombosis & paralysis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u> <u>?</u> <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 July</u> , 1957, to <u>16 Aug</u> , 1957, that I last saw the deceased alive on <u>16 Aug</u> , 1957, and that death occurred at <u>5:45 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave. Bethesda, Maryland</u> DATE SIGNED <u>16 Aug 57</u>			
ACTUAL SIGNATURE <u>Herbert Martyn Jr</u>		M.D. <u>5029 Bethesda Ave</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>		<u>5029 Bethesda Ave. Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/19/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery Co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda,</u>		24a. REC'D BY REGISTRAR <u>8-22-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU ONE 18

65130

NAME OF DECEASED <i>James G. Ay</i>		AGE <i>2</i>	SEX <i>M</i>	RACE <i>W</i>	DATE OF BIRTH <i>1955</i>
PLACE OF BIRTH <i>James G. Ay</i>		DATE OF DEATH <i>1957</i>	TIME OF DEATH <i>10:00 AM</i>	PLACE OF DEATH <i>James G. Ay</i>	CAUSE OF DEATH <i>Heart Disease</i>
DISEASE OR INJURY <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>			
SIGNATURE OF PHYSICIAN <i>James G. Ay</i>		SIGNATURE OF REGISTRAR <i>James G. Ay</i>			
SIGNATURE OF WITNESS <i>James G. Ay</i>		SIGNATURE OF WITNESS <i>James G. Ay</i>			

BUREAU V. S.

AUG 26 1957

RECEIVED

Robert J. Campbell - 1957 Wm. Ave. Bethesda, Md.

08622

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> 16 X 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u>				d. STREET ADDRESS <u>2606 Hughes Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Stout</u> Last <u>Stout</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/27/75</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N J</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Aaron Newman</u>				14. MOTHER'S MAIDEN NAME <u>Neaves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hosp Records</u>			
17. INFORMANT Address <u>Hosp Records</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous</u> <u>pneumoperitoneum</u> <u>578x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupture of stomach</u> DUE TO (c) <u>15 min</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 31</u> , 19 <u>57</u> , to <u>August 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 31</u> , 19 <u>57</u> , and that death occurred at <u>7:50</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>				ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring Md.</u>			
DATE SIGNED <u>Aug. 1, 57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MONMOUTH MEMORIAL PARK NEW SHREWSBURY, N.J.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler, 1756 Pa. Ave. N.W.D.C.</u>				ADDRESS <u>1756 Pa. Ave. N.W.D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>8/3/57</u>	
24b. REGISTRAR'S SIGNATURE <u>William Reed</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		SOCIAL HISTORY [Faint text]	
PREVIOUS ILLNESS [Faint text]		PREVIOUS SURGERY [Faint text]		PREVIOUS TRAUMA [Faint text]	
PREVIOUS DRUGS [Faint text]		PREVIOUS ALCOHOL [Faint text]		PREVIOUS TOBACCO [Faint text]	
PREVIOUS RADIATION [Faint text]		PREVIOUS CHEMICALS [Faint text]		PREVIOUS OTHER [Faint text]	
PREVIOUS INJURY [Faint text]		PREVIOUS DISEASE [Faint text]		PREVIOUS TREATMENT [Faint text]	
PREVIOUS HOSPITALIZATION [Faint text]		PREVIOUS PHYSICIAN [Faint text]		PREVIOUS NURSE [Faint text]	
PREVIOUS LABORATORY [Faint text]		PREVIOUS X-RAY [Faint text]		PREVIOUS OTHER [Faint text]	
PREVIOUS PATHOLOGY [Faint text]		PREVIOUS ANATOMY [Faint text]		PREVIOUS PHYSIOLOGY [Faint text]	
PREVIOUS PSYCHOLOGY [Faint text]		PREVIOUS SOCIOLOGY [Faint text]		PREVIOUS ETHNOLOGY [Faint text]	
PREVIOUS LINGUISTICS [Faint text]		PREVIOUS HISTORY [Faint text]		PREVIOUS GEOGRAPHY [Faint text]	
PREVIOUS METEOROLOGY [Faint text]		PREVIOUS ASTRONOMY [Faint text]		PREVIOUS PHYSICS [Faint text]	
PREVIOUS CHEMISTRY [Faint text]		PREVIOUS BIOLOGY [Faint text]		PREVIOUS MEDICINE [Faint text]	
PREVIOUS DENTISTRY [Faint text]		PREVIOUS VETERINARY [Faint text]		PREVIOUS AGRICULTURE [Faint text]	
PREVIOUS FISHERY [Faint text]		PREVIOUS MINING [Faint text]		PREVIOUS MANUFACTURING [Faint text]	
PREVIOUS TRANSPORTATION [Faint text]		PREVIOUS COMMUNICATIONS [Faint text]		PREVIOUS PUBLIC UTILITIES [Faint text]	
PREVIOUS RECREATION [Faint text]		PREVIOUS RELIGION [Faint text]		PREVIOUS POLITICAL [Faint text]	
PREVIOUS ECONOMIC [Faint text]		PREVIOUS LEGAL [Faint text]		PREVIOUS ARTS [Faint text]	
PREVIOUS SCIENCE [Faint text]		PREVIOUS TECHNOLOGY [Faint text]		PREVIOUS ENVIRONMENTAL [Faint text]	
PREVIOUS SPACE [Faint text]		PREVIOUS OCEANOGRAPHY [Faint text]		PREVIOUS METEORITICS [Faint text]	
PREVIOUS COSMOLOGY [Faint text]		PREVIOUS ASTROPHYSICS [Faint text]		PREVIOUS COSMOPOLITAN [Faint text]	
PREVIOUS COSMOPOLITAN [Faint text]		PREVIOUS COSMOPOLITAN [Faint text]		PREVIOUS COSMOPOLITAN [Faint text]	

RECEIVED
 AUG 5 1957
 BUREAU V. S.

1

08731

CERTIFICATE OF DEATH

Reg. Dist. No.

08735/4

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10512 Kinloch Road (Hillendale)		d. STREET ADDRESS 10512 Kinloch Rd. (Hillendale)	
3. NAME OF DECEASED (Type or print) First Mary Middle Belle Last Stultz		4. DATE OF DEATH Month August Day 16 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1874
9. AGE (In years last birthday) 74 82rs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Woodstock, Va.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Baker		14. MOTHER'S MAIDEN NAME Frances Copp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John S. Stultz-10512 Kinloch Rd. Spg. Md.		Address Silver	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (New) 420.0 DUE TO Coronary Thrombosis (old) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Arteriosclerotic Heart Disease (c) Undetermined		INTERVAL BETWEEN ONSET AND DEATH 2 days Nov 1954 Apr 1955 May 1955
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **June 22, 19 57** to **Aug 16, 19 57**, that I last saw the deceased alive on **Aug 15, 19 57**, and that death occurred at **6:30 PM**, from the causes and on the date stated above.

ACTUAL SIGNATURE George L. Ball	ADDRESS (Street, city or town, state) 7835 Eastern Ave Silver Spring Md	DATE SIGNED Aug 16, 1957
PHYSICIAN'S NAME (Type) George L. Ball	M.D. Silver Spring Md	

22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial	22b. DATE THEREOF 8/19/57	22c. NAME OF CEMETERY OR CREMATORY Massanutten Cemetery Woodstock, Virginia	22d. LOCATION (City, town, or county) (State) Woodstock, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR AUG 20 1957	
24b. REGISTRAR'S SIGNATURE Frances Petley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 20 1957

BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08736
Reg. Dist. No. 223

08623

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>11 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7114 Popular Ave.</u>			d. STREET ADDRESS <u>1 7114 Popular Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ella D</u> <u>Sussex</u> <u>Lost</u>			4. DATE OF DEATH <u>8/12/57</u> <u>Month</u> <u>Day</u> <u>Year</u> <u>19</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/65</u>	9. AGE (in years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>John Dilzoll</u>		
14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Marguerite S. Terry</u> Address <u>Item 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>904.9 Fracture of rt. hip June 1957</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <u>Prince George's County</u>			20g. (State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DATE SIGNED <u>8/12/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Prince George's County</u>		22e. (State) <u>MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>	
24a. REC'D BY REGISTRAR <u>7/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>William Noel</u>		24c. DATE <u>7/15/57</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 16 1957

BUREAU Y. S.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08732

CERTIFICATE OF DEATH

Reg. Dist. No.

08737 217

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 73 Montgomery County General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x/ Gaithersburg,	
f. STREET ADDRESS Rt. #2		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willnett Middle Tates Last Tates		4. DATE OF DEATH Month August Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/04
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Work (Domestic)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Record	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular accident 590x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant Hypertension (c) Acute Nephritis			INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 month 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/1 , 19 57 , to 8/15 , 19 57 , that I last saw the deceased alive on 8/14 , 19 57 , and that death occurred at 8:13 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE G. F. Meadors, M.D.		M.D.	
PHYSICIAN'S NAME (Type) G. F. Meadors, M.D.		Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/19/57	22c. NAME OF CEMETERY OR CREMATORY Brooke Grove,	22d. LOCATION (City, town, or county) (State) Laytonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sumner		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR Aug 20 1957		24b. REGISTRAR'S SIGNATURE Gertrude L. L...	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

AUG 20 1957

RECEIVED

08733

CERTIFICATE OF DEATH

Reg. Dist. No. 150

DEPUTY FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 x should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK DELOS THOMPSON, SR.		4. DATE OF DEATH Month Day Year August 12, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1889
9. AGE (In years (birthdays) yrs. 68		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Y.M.C.A.		10b. KIND OF BUSINESS OR INDUSTRY Sec.	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hiram Thompson		14. MOTHER'S MAIDEN NAME Laura B. Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 119-26-1001	
17. INFORMANT Mrs. Eva H. Thompson		Address Hyattstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ② Hypertension DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-11-1957 to 8-11-1957 that I last saw the deceased alive on 8-11-1957 , and that death occurred at 2:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church Frederick Md DATE SIGNED 8-11-57			
ACTUAL SIGNATURE Rex R. Martin		M.D. Dr. Rex R. Martin	
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug. 13, 1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Blacksburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR AUG 15 1957	
ADDRESS Frederick, Maryland		24b. REGISTRAR'S SIGNATURE Debra B. Smith	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

Name of Deceased		Sex		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John J. Thompson		Male		White		1908		Baltimore, Md.		Baltimore, Md.		Heart Disease		1957		10:00 AM		Home		J. H. Smith		J. H. Smith	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Alcohol Consumption		Tobacco Use		Last Meal		Last Seen Alive		Burial Place		Burial Date		Burial Time	
Carpenter		Married		High School		Catholic		None		Occasional		Occasional		None		None		Catholic Cemetery		1957		10:00 AM	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness	
1957		10:00 AM		Home		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

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AUG 15 1957
BUREAU V. S.

TO HOSPITAL OR BURIAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register of prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

08734		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		08740	
Item 1c Film G219 8-21-57 et		CERTIFICATE OF DEATH		Reg. Dist. No. 216	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7161 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4416 Clearfield Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Donald Middle Howard Last Urso		4. DATE OF DEATH Month August Day 8 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1950	9. AGE (In years last birthday) 6 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Joseph H. Urso		14. MOTHER'S MAIDEN NAME Roberta Kilby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute ulceration ileum & Massive Gastrointestinal hemorrhage 204.0 DUE TO Leukemia, acute, lymphocytic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 27, 1957 , to August 6, 1957 , that I last saw the deceased alive on August 6, 1957 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Roger Lester		M.D. The Clinical Center		DATE SIGNED 8/6/57	
PHYSICIAN'S NAME (Type) Roger Lester, M. D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/9/57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	
				22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 8-8-57	
				24b. REGISTRAR'S SIGNATURE Beau M. Thompson	

AUG 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08741.
08735 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleveland</u> 72x-3		d. STREET ADDRESS <u>13914 Benwood Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ronald</u> Middle <u>Joseph</u> Last <u>WACHOWSKI</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Dec. 1936</u>
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward WACHOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>Sophie CHUDZIK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes, Currently</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Mother) Mrs. Sophie WACHOWSKI (Same As #2)</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Fracture of Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>28 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Fractures of Face</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was driver of auto which failed to make curve on highway</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:00</u> Hour <u>2:00</u> a.m. <u>Aug. 30</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Arlington, Arlington, Virginia</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cleveland, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>		ADDRESS <u>521 Wisconsin Ave., Bethesda, Md</u>	
24a. REC'D BY REGISTRAR <u>8-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Ranelly</u>	

BUREAU V. S.

SEP 4 1957

RECEIVED

08736

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Washington Last Washington		4. DATE OF DEATH Month August Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/57
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Virginia I. Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record (Mother)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cross junction - 4 of body DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/26 , 19 57 , to 8/26 , 19 57 , that I last saw the deceased alive on 8/26 , 19 57 , and that death occurred at 9:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED _____			
ACTUAL SIGNATURE A. D. Bonifant M.D. _____			
PHYSICIAN'S NAME (Type) A. D. Bonifant, M. D. Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/30/57	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sander		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR SEP 4 1957		24b. REGISTRAR'S SIGNATURE Gertrude L. Lacey	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073275XV0

BUREAU V. S.

SEP 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH-DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08743
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) William Washington		4. DATE OF DEATH Aug. 27, 1957	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/23
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR 19 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Washington		14. MOTHER'S MAIDEN NAME Henrietta Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. Henrietta Washington, Gaithersburg, Md.	
17. INFORMANT Henrietta Washington, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration 802 x DUE TO Multiple compound fractures of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 hrs. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of rt forearm		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Struck by freight train at B & O crossing		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 7:25 p.m. 8/26 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RR Crossing		20f. (City or town) Gaithersburg, Montg. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/30/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National,		22d. LOCATION (City, town, or county) Arlington, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Saunden		24a. REC'D BY REGISTRAR SEP 3 1957	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

RECEIVED
SEP 3 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08744

08738

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 10202 MENLO AVE			
3. NAME OF DECEASED (Type or print) CLARENCE M WHIPPLE				4. DATE OF DEATH Aug 9 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug 25, 1872	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Store Employee		11. BIRTHPLACE (State or foreign country) N Y		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Calvin Whipple				14. MOTHER'S MAIDEN NAME Satira Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hester M. Whipple		Address 10202 Menlo Sil Spr Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation (acute) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1-2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic stenosis (from old duodenal ulcer)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11 , 19 57 , to 8/9 , 19 57 , that I last saw the deceased alive on 7/24 , 19 57 , and that death occurred at 9:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Aud				DATE SIGNED 906 Colverville Rd Silver Spring Md			
PHYSICIAN'S NAME (Type) WILLIAM D AUD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
cremation		8-12-57		Cedar Hill		Seatons Md	
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home				ADDRESS 4812 Ga Ave NW Wash DC		24a. REC'D BY REGISTRAR Francis Potter	
				DATE AUG 14 1957			

1

BUREAU V. S.

AUG 14 1957

RECEIVED

08624

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE District of Columbia b. COUNTY Washington, DC			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Sanitarium				d. STREET ADDRESS 7410 Georgia Ave NW			
3. NAME OF DECEASED (Type or print) Hessie Thomas White				4. DATE OF DEATH Aug 26 1957			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1909 7-30-XXXX	9. AGE (In years last birthday) 48 yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Operator		10b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co.		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Thomas White				14. MOTHER'S MAIDEN NAME Bessie Aldridge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-8718		17. INFORMANT Chart a wife, 7410 Ga. Ave., Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarct myocardium left ventricle DUE TO (c) Coronary thrombosis				INTERVAL BETWEEN ONSET AND DEATH 12 hour 2 days 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-22-1941 , to 8-26-1957 , that I last saw the deceased alive on 8-26-57 , 19 57 , and that death occurred at 4:01 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Shoemaker M.D.				ADDRESS (Street, city or town, state) 8005 Woodbury Drive Silver Spring, Md.			
PHYSICIAN'S NAME (Type) K.C. SHOEMAKER, M.D.				DATE SIGNED 8-28-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 8/29/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY SHADY GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) DUNN, NORTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR J. M. Rodes	
				DATE 8-28-57		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		1912		Baltimore, Md.		Carpenter		Married		White		Roman Catholic		High School		Middle Class		Baltimore, Md.		Aug 28, 1957		10:30 AM		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris			
21. PLACE OF INTERMENT		22. DATE OF INTERMENT		23. TIME OF INTERMENT		24. NAME OF FUNERAL HOME		25. NAME OF FUNERAL HOME		26. NAME OF FUNERAL HOME		27. NAME OF FUNERAL HOME		28. NAME OF FUNERAL HOME		29. NAME OF FUNERAL HOME		30. NAME OF FUNERAL HOME		31. NAME OF FUNERAL HOME		32. NAME OF FUNERAL HOME		33. NAME OF FUNERAL HOME		34. NAME OF FUNERAL HOME		35. NAME OF FUNERAL HOME		36. NAME OF FUNERAL HOME		37. NAME OF FUNERAL HOME		38. NAME OF FUNERAL HOME		39. NAME OF FUNERAL HOME		40. NAME OF FUNERAL HOME	
St. Mary's Cemetery		Aug 29, 1957		10:00 AM		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris			

BUREAU V. A.

AUG 29 1957

RECEIVED

08747

08739

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 4813 DAVENPORT ST. NW. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN RAWTON WILLIAMSON				4. DATE OF DEATH Month Day Year Aug 18 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 17 - 1894 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD MAIL CLERK		10b. KIND OF BUSINESS OR INDUSTRY P.O. DEPT.		11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PAGE WILLIAMSON				14. MOTHER'S MAIDEN NAME MARGARET BURKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding Duodenal ulcer DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 24 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1953 to present , 19 57 , that I last saw the deceased alive on Aug 17 , 19 57 , and that death occurred at 10 AM , from the causes and on the date stated above. C. P. Ryland ADDRESS (Street, city or town, state) 4400 - 49 St. NW. Washington DC DATE SIGNED							
ACTUAL SIGNATURE				M.D. 4400 - 49 St. NW. Washington DC			
PHYSICIAN'S NAME (Type) CHARLES P. RYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		8/20/57		Shannon Ave		Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Chung Pham Thong Home				DATE 8-26-57		Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		MALE		35		JAN 15 1922		NEW YORK	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
DATE OF MARRIAGE		DATE OF DIVORCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 15 1957		JAN 15 1957		JAN 15 1957		NEW YORK		HEART DISEASE	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR	
CLERK		HIGH SCHOOL		CATHOLIC		WHITE		WHITE	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S BIRTH	
JAMES J. JONES		JANE J. JONES		CLERK		HOUSEWIFE		JAN 15 1922	
MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S BIRTH		MOTHER'S BIRTH	
JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1922		JAN 15 1922	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JAN 15 1957		NEW YORK		HEART DISEASE		NATURAL		12345	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
JAMES J. JONES		JANE J. JONES		JANE J. JONES		JANE J. JONES		JANE J. JONES	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957		JAN 15 1957	

RECEIVED
JUN 27 1957
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08740

CERTIFICATE OF DEATH

08748

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY MONTGOMERY CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Wash. b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORBECK MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHILOMENA REST HOME.				d. STREET ADDRESS 1209 Holly St.			
3. NAME OF DECEASED (Type or print) First JOHN L Middle WISE Last				4. DATE OF DEATH Month 8/26/57 Day 19 Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 11 1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES B WISE.				14. MOTHER'S MAIDEN NAME LUELLA ARMENTROUT.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Grace W Morrison, Dayton Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT LUNG 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 23 , 19 55 , to Aug 26 , 19 57 , that I last saw the deceased alive on Aug 25 , 19 57 , and that death occurred at 3:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W F Greaney MD M.D. 7542 12th St NW WASH D.C. Aug 26, 1957 PHYSICIAN'S NAME (Type) WM F GREANEY MD 7542 12TH ST NW WASH D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial.		22b. DATE THEREOF 8/28/57		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Pr Georges Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W F Greaney MD				24a. REC'D BY REGISTRAR 7/30/57		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]		CAUSE OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	

BUREAU V. E.

SEP 3 1957

RECEIVED

BUR

08741

CERTIFICATE OF DEATH

Reg. Dist. No. 21648

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>24 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>W.</u> Last <u>Wynkoop</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 11, 1884</u>	
9. AGE (In years last birthday) yrs. <u>73</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Mitchell Wells</u>		14. MOTHER'S MAIDEN NAME <u>Gardiner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Edna Mae Walton (daughter)</u>		Address <u>11407 Grayling Lane</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary a.s. H.D.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u> <u>24 days</u> <u>Indef</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from <u>May 1, 1957</u> to <u>8/6/1957</u> , that I last saw the deceased alive on <u>8/6/1957</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <u>Rockville Md</u>		DATE SIGNED <u>8/6/57</u>		ACTUAL SIGNATURE <u>Stephen N. Jones</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>8434 La 55th</u>	
24a. REC'D BY REGISTRAR <u>8-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 of this certificate should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AUG 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08750

Reg. Dist. No.

773

C8625

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma ryla nd b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakoma Park		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La ngley Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. and Hospital				d. STREET ADDRESS 1407 1/2 Merimack Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle Young Last				4. DATE OF DEATH Month 8 Day 12 Year 57			
5. SEX female		6. COLOR OR RACE col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/11	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Caledonia, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Scott				14. MOTHER'S MAIDEN NAME Emma Manan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 8-16-57		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery, Rockland, Va.	
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Son ADDRESS 467 N. St. N.W.				24a. REC'D BY REGISTRAR AUG 16 1957		24b. REGISTRAR'S SIGNATURE J. H. H. H.	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 50 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS 95812			
3. NAME OF DECEASED (Type or print) First Lillian Middle Cobb Last YOUNG				4. DATE OF DEATH Month August Day 25 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1906		9. AGE (In years lost birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Califronia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lawrence Arthur COBB				14. MOTHER'S MAIDEN NAME Rosemarie AMBROSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Oliver L. YOUNG (Husband), (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, left lower lung 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic CARCINOMA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 days 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 6, 1957 to August 25, 1957 , that I last saw the deceased alive on August 25, 1957 , and that death occurred at 3:14 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wm. B. Ingram M.D. U.S. Naval Hospital, Bethesda, Md. 8-26-57							
ACTUAL SIGNATURE Wm. B. Ingram M.D. U.S. Naval Hospital, Bethesda, Md. 8-26-57							
PHYSICIAN'S NAME (Type) William B. Ingram, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 8-26-57	
				24b. REGISTRAR'S SIGNATURE Harry B. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. PLACE OF BIRTH		2. PLACE OF DEATH	
3. DATE OF BIRTH		4. DATE OF DEATH	
5. SEX		6. RACE	
7. OCCUPATION		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. MEDICAL HISTORY	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER	
15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF CLERK	

BUREAU V. S.

JUG. 27. 1957

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